Department of Homeland Security
Office of Health Affairs
Medical Quality Management Branch

US Immigration and Customs Enforcement (ICE)
Health Services Corps (ISHC)

Continuous Quality Improvement (CQI) and Medical Record Audit Tc

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The US Department of Homeland Security (DHS) is acknowledged as the sponsor of this work.

ICE HEALTH SERVICE CORPS (IHSC) - CONTINUOUS QUALITY IMPROVEMENT AUDIT TOOL - FY 2017

You will report EVERY quarter on ALL MEASURES that follow. There are 28 measures in total.

- Grievances
- Suicide Watch
- Hunger Strikes
- Medication Errors
  - o Medication Administration Errors
  - o Prescribing/Ordering Errors
  - o Pharmacy Order Errors
  - o Self-administered medications, continuity of medication and medication refusals

Sample Size: For each of these components, you will review 10 charts (unless findings fall below the threshold established [thresholds are listed after each item] – then you must review 10 additional records). NOTE: If there are less than 10 charts, then review 100% of those charts that are applicable.

- Medication Refusal
- Pregnancy Audit
- Medical Housing Unit
- Screening and Health Assessment
- Hypertension
- Diabetes
- Asthma
- HIV
- Tuberculosis

- Seizure Disorder
- Sick Call/Urgent Care
- Mental Illness with Psychotropic Medication
- Dental Care
- Continuity of Care
- Reasonable Accommodations

- Treatment of Disability
- Diagnostic Services and Specialty Care Access
- Laboratory and Diagnostics
- Credentialing
- Mortality Review
- Medical Recordkeeping Practices

THRESHOLDS FOR COMPLIANCE: Each indicator has a percentage of compliance required (written next to it). If you fall below this threshold for compliance, you must submit a corrective action plan for it. The corrective action plan should be written in the section following the data.

GRIEVANCES (IMPORTANT)

Facility: Stewart Detention Center
Reviewer: LCDR (b)(6)
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: Obtain the numbers from the grievance logs.

GRIEVANCES		
	Number	Percentage of Total Grievances
1. Total number of grievances received within quarter.	8	
2. Number of grievances addressed* within 5 business days.	6	75%
3. Number of grievances related to access to care.	5	63%
4. Number of grievances related to quality of care.	3	38%
Comments: A total of 8 grievances were received within the quarter; 1 -detainee transferred out of the facility the next day and his grievance could not be processed.		
Corrective Action Plan(s) (if appropriate): **An alternate staff member needs to be identified; He/she who will address grievances when the primary staff member is unvailable, thus ensuring grievances are addressed in a timely manner.**		

SUICIDE WATCH (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: (b)(6)
Quarter/Fiscal Year: 4th Qtr/2017

INSTRUCTIONS: Enter the total number of detainees in the detention facility in the field "Total Patient Population". Obtain the numbers for 1-8 from intake screenings, suicide watch logs and medical records.

SUICIDE WATCH		Total Patient Population →	
	Number	Percentage of Total Number on Suicide Watch	Percentage of Total Patient Population
1. Total number of detainees on suicide watch during specified timeframe. (for suicidal ideation, actions)	13		
2. Number of detainees (from number above) on suicide watch during specified time frame who made an actual suicide attempt.	1	8%	
3. Number of incident reports submitted. (required for detainees with suicidal attempt)	1	8%	
4. Number of detainees on suicide watch who were evaluated by behavioral health professionals within 24 hours, unless emergent.(in which case the evaluation should be immediate)	13	100%	
5. Number of detainees on suicide watch (from number above) who were seen previously by IHSC for mental health issues.	8	62%	
6. Number of detainees on suicide watch with daily evaluations done by qualified medical staff.	13	100%	
7. Number of detainees on suicide watch with appropriate documentation. (i.e. 15 minute and 8 hour documentation)	2	15%	
8. Number of detainee on suicide watch that received follow up post/after discharge from suicide watch at interval consistent with the level of acuity. (PBNDS)	11	85%	
Comments: #7: 15 minute forms completed by Correctional Officers are missing.			
Corrective Action Plan(s) (if appropriate): BHPs will ensure that the missing observation logs are located, completed in their entirety and forwarded to MRTs for scanning into the detainees' EMR. All staff will be reminded, educated and trained on importance of ensuring that observation logs are thoroughly completed and accounted for daily. Core Civis leadership will be informed during quarterly suiced prevention meeting to educate staaf on maintaining all forms			

HUNGER STRIKES (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: Obtain the numbers from hunger strike logs and medical records.

HUNGER STRIKES		
	Number	Percentage of Total Number on Hunger Strikes
1. Total number of detainees on hunger strikes within the quarter.	16	
2. Number of detainees requiring medical intervention. (intravenous therapy) ON SITE (not those off-site)	0	0%
3. Number of detainees requiring medical intervention (intravenous therapy) ON SITE(not those off-site) for whom an incident report was submitted.	0	0%
4. Number of detainees on hunger strike with complete documentation. (daily vital signs, daily weights, intake and output)	1	7%
5. Number of detainees on hunger strikes with provider evaluation documented.	16	100%
6. Number of detainees on hunger strike requiring court-ordered force-feeding on site.	0	0%
7. Number of detainees on hunger strike requiring court-ordered force-feeding in hospital.	0	0%
Comments: Nursing staff is not using the MHU: Hungerstrike Monitoring Form/MHU: Intakes&Outputs form to record intakes/outputs or significant findings from labs. 1-record revealed detainee refusing nursing assessments. Every detainee on hunger strike had regular provider contact throughout their time on hunger strike		
Corrective Action Plan(s) (if appropriate): In service training will be provided to the nursing staff on proper document ion related to hunger strike. Medical staff will continue to conduct their evaluations and make eCW entries for all MHU pts in a timely manner		

MEDICATIONS (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT [redacted]
Quarter/Fiscal Year:	4th Quarter 2017

INSTRUCTIONS: Place the number of medication errors (from incident reports) in the column "Number of Errors". Place the number of incident reports submitted in the column next to it. If none, put "0". If not applicable, enter "NA". Do not leave any blank.

MEDICAL ADMINISTRATION ERRORS

	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong medications given.	0	0
2. Number of wrong patients receiving medication.	0	0
3. Number of medications given at wrong time.	0	0
4. Number of medications missed.	6	3
5. Number of medications administered via wrong route.	0	0
6. Number of wrong doses given.	0	0
7. Number of transcription errors.	0	0
8. Number of expired prescriptions given.	0	0
9. Number of blank spaces on medication administration record. (i.e. no documentation of missed medication)	0	0
10. Other **LOST MEDS**	0	0
TOTAL:	**6**	**3**

Comments:
-6 medications were missed (Detainees failed to show up to pill line).

Corrective Action Plan(s) (if appropriate): Will continue to communicate with the correctional officers to ensure that detainees are escorted to the pill line for their meds; Detainees not willing to come for their meds will sign refusal forms

PRESCRIBING/ORDERING ERRORS

	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong patients receiving medication	0	0
2. Number of wrong drug - indication	1	1
3. Number of wrong drug - allergy	0	0
4. Number of wrong drug – drug interaction	0	0
5. Number of wrong doses	1	1
6. Number of wrong dosing schedules	0	0
7. Number of orders written incorrectly	2	1
8. Number of medication orders not forwarded to pharmacy	0	0
9. Other	0	0
TOTAL:	**4**	**3**

Comments:
2 orders were written incorrectly; 1 drug had the wrong indication; and 1 wrong dose

Corrective Action Plan(s) (if appropriate):
Improved communication between providers, nurses, and pharmacy ; Educate providers on double checking orders; Nurses should read back orders to the providers after taking verbal orders

SELF-ADMINISTRERED MEDICATIONS, CONTINUITY OF MEDICATION, and MEDICATION REFUSAL

	Whole Numbers	Yes/No/NA
1. Estimated number of patients on self-administered medication. (check with pharmacy)	690	
2. If detainee requires continuation of medication, was medication ordered within 24 hours from completion of intake screening? (Review 10 random medical records: Note percent compliance if less than 100%; if 100%, enter "Yes".)		Yes
3. Average lapse time from order to first dose of medication, if greater than 24 hours?	0	
4. Other		

Comments:
Meds provided within 24 hrs however, it is unknown when detainee chooses to take first dose.

Corrective Action Plan(s) (if appropriate):
None

PHARMACY ERRORS		
	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong patients.	0	0
2. Number of wrong medications.	1	1
3. Number of wrong doses.	0	0
4. Number of wrong labels.	0	0
5. Number of wrong routes.	0	0
6. Number of MAR errors. (misprinted, medication missing)	2	2
TOTAL:	**3**	**3**

Comments:
#2- Extended release medication given instead of immediate release #6- Future start date for a medication not printed in MAR

Corrective Action Plan(s) (if appropriate):
MARs to be reviewed by the Clinic Coordinator/Nurse Manager daily

MEDICATION REFUSAL

Facility: Stewart Detention Center
Reviewer: LT (b)(6)
Quarter/Fiscal Year: 4th Quarter 2017

PURPOSE: To assess notification of prescribing clinician of poor adherence to medication orders.

Source: Medication administration records, medical record RN, MLP or physician can review.

Sample: Identify 10 patients from MARs who have missed medication on three consecutive days or four or more doses in a week.

Instructions: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Documented refusal in the medical record (with signature of detainee, witness)?
2	Explanation of risks and benefits documented in the medical record?
3	Documentation that prescribing clinician has been notified if 3 consecutive days or 3 consecutive doses and/or 50% of doses missed within 7 days?
4	Documentation of clinician response in the medical record?
5	If detainee refused to sign refusal form, was it documented on the form?

MEDICATION REFUSAL							
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5
1	(b)(6);(b)(7)(C)	1	1	1	1	NA
2		1	1	1	1	NA
3		1	1	1	1	1
4		1	1	1	1	NA
5		1	1	1	1	1
6		1	1	1	1	NA
7		1	1	1	1	1
8						
9						
10						
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%

Comments:
N/A

Corrective Action Plan(s) (if appropriate):
N/A

PREGNANCY AUDIT (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT (b)(6)
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: A health care provider will review 100% of the charts of the pregnant patients during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable.

Sample size: 100%

Item #	Measure
1	Was an OB-GYN consult ordered and the scheduled appointment time documented within 7 days of identification of condition? (Not necessarily seen within 7 days) (100%)
2	Prenatal vitamins prescribed? (100%)
3	Proper diet ordered? (100%)
4	Patient education documented at each encounter? (100%)
5	Records reviewed by provider after OB appointment? (100%)
6	Appropriate prenatal labs (consideration for HIV, STI, and viral hepatitis) ordered if not obtained from OB-GYN? (100%)

PREGNANCY AUDIT

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6
1	N/A	NA	NA	NA	NA	NA	NA
2							
3							
4							
5							
6							
7							
8							
9							
10							
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%

Comments:
N/A; all male facility

Corrective Action Plan(s) (if appropriate):
N/A

MEDICAL HOUSING UNIT (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT (b)(6)
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of patients who were admitted to the MHU during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable.

To RANDOMLY select, list out the total number of MHU patients for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

ITEM #	MEASURE
1	Admitting history/current diagnosis or issues documented on the MHU progress note (to be completed by a physician/MLP or appropriate clinician according to scope of practice)? (100%)
2	Appropriate exam documented relevant to the reason for the MHU stay? – e.g. dental, medical, or behavioral health exam? (100%)
3	Provider rounds documented as noted in the treatment plan, if applicable (90%)
4	Treatment plan includes specific instructions for nursing and appropriate precautions or interventions for infectious disease? (90%)

5 Nursing care plan present? (90%)
6 Nursing care follow-up documented? (100%)
7 Nursing progress notes present for each shift? (100%)
8 24 hour chart review indicated with signature, date and time of review? (90%)
9 Discharge from MHU documented, if applicable (100%)
10 Language Access: Use of translator, provider fluency in language, or English-speaking detainee is documented? (100%)

MEDICAL HOUSING UNIT

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10
1	[redacted]	1	1	1	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1	1	1	1
3		1	1	1	1	1	1	1	1	1	1
4		1	1	1	1	1	1	1	1	1	1
5		1	1	1	1	1	1	1	1	1	1
6		1	1	1	1	1	1	1	1	NA	1
7		1	1	1	1	1	1	1	1	0	1
8		1	1	1	1	1	1	1	1	1	1
9		1	1	1	1	0	1	1	NA	1	1
10		1	1	1	1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	90%	100%	100%	100%	90%	100%

Comments:
-No nursing care plan with one pt. record

Corrective Action Plan(s) (if appropriate):
In service training to be provided to the nurses on Nursing Care Plan.

Add additional 10 records if you fall below the threshold in the table to the right.

MEDICAL HOUSING UNIT - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
	PERCENT COMPLIANCE										

Comments:

Corrective Action Plan(s) (if appropriate):

SCREENING AND HEALTH ASSESSMENT (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT [redacted]
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review the appropriate number (see page 1) of randomly selected records for patients that have been at the facility for more than two weeks during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

Sample Size: See Instructions in Row 3

Item # Measure
1 Initial screening completed within 12 hours of admission to facility? (100%)
2 All required areas of the intake template in eCW are completed? (100%)
3 TB screening completed during medical intake if applicable (PPD or CXR)? (100%)
4 PPD read within 48-72 hours? (N/A if CXR performed) (100%)
5 TB clearance properly documented? (100%)
6 Was there timely (NLT 2 working days after identification) follow-up for significant findings of acute and chronic conditions? (100%) (A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health) (100%)
7 Was health assessment completed within 14 days? (100%)
8 Was health assessment completed within 7 days for children? (Family Residential Centers) (100%)
9 Was health assessment completed for patients with chronic illnesses within two working days? (100%)
10 Health assessment (health history and hands-on physical examination) completed by licensed physician/PA/NP/RN (if completed by RN, must have documented training) (100%)
11 If applicable, documentation of transfer summary reviewed within 12 hours? (100%)
12 Patient education documented at each encounter? (100%)
13 Language access: Use of translator, provider fluency in language, or English-speaking patient is documented. (100%)

SCREENING AND HEALTH ASSESSMENT

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
1	[redacted]	1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
2		1	1	NA	NA	1	NA	1	NA	NA	1	1	1	1
3		1	1	NA	NA	1	NA	1	NA	NA	1	1	1	1
4		1	1	1	NA	1	NA	NA	NA	NA	NA	1	1	1
5		1	1	NA	NA	1	1	NA	NA	1	1	1	1	1
6		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
7		1	1	NA	NA	1	NA	1	NA	NA	1	1	1	1
8		1	1	NA	NA	1	NA	1	NA	NA	1	1	1	1
9		1	1	NA	NA	1	NA	1	NA	NA	1	1	1	1
10		1	1	NA	NA	1	1	NA	NA	1	1	1	1	1

SCREENING AND HEALTH ASSESSMENT - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
11														
12														
13														
14														
15														
16														
17														
18														
19														
20														

PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

Add additional 10 records if you fall below the threshold in the table to the right.

HYPERTENSION (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT (b)(6)
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with hypertension during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with hypertension for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample Size: See Instructions in Row 3

Item #	Measure
1	Blood pressure reading documented at intake? (100%)
2	Patient seen by medical provider within two business days of illness identification (100%)
3	Patient was referred to MLP or higher, if exam was completed by RN (95%)
4	Patient has treatment plan documented? (95%)
5	Diagnosis listed in provider SOAP note? (100%)
6	Diagnosis listed on problem list? (100%)
7	Baseline labs obtained (CBC, CHEM, lipid profile, UA & EKG) and reviewed within 30 days of illness identification? (100%)
8	Patient education documented at each encounter? (100%)
9	Language access: Use of translator, provider fluency in language or English speaking patient is documented? (100%)

HYPERTENSION

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
1	(b)(6),(b)(7)(C)	1	1	NA	1	1	1	1	1	1
2		1	1	NA	1	1	1	1	1	1
3		1	1	NA	1	1	1	1	1	1
4		1	1	NA	1	1	1	1	1	1
5		1	1	NA	1	1	1	1	1	1
6		1	1	NA	1	1	1	1	1	1
7		1	1	NA	1	1	1	1	1	1
8		1	1	NA	1	1	1	1	1	1
9		1	1	NA	1	1	1	1	1	1
10		1	1	NA	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

HYPERTENSION - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

Add additional 10 records if you fall below the threshold in the table to the right.

DIABETES (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT (b)(6)
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with diabetes during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with diabetes for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample Size: See Instructions in Row 3

Item #	Measure
1	Was PE-C completed within two business days if diabetes was identified at time of arrival? (100%)
2	Documented blood sugar on intake (if diabetes identified at intake) or documented reason for not testing e.g. detainee just ate food one hour ago? (90%)
3	Diagnosis listed in provider SOAP note (100%)
4	Diagnosis listed on problem list? (100%)
5	Baseline A1C obtained within 30 days of arrival or within past 3 months? (100%)
6	Baseline measurement of lipids within 30 days? (100%)
7	Documented prescription of aspirin, as clinically indicated? (80%)
8	Degree of control (goal of HgbA1C < 8.0) documented in treatment plan? (90%)
9	Was a strategy to attain diabetes control documented if HgbA1C was above goal? (100%)
10	Patient education documented at each encounter? (100%)
11	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

DIABETES

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11
1	b(6),(b)(7)(C)	1	0	1	1	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1	NA	NA	1	1
3		1	1	1	1	NA	NA	1	NA	NA	1	1
4		1	1	1	1	1	1	0	1	1	1	1
5		1	1	1	1	1	1	1	NA	NA	1	1
6		1	1	1	1	1	1	0	NA	NA	1	1
7		1	0	1	1	1	1	1	1	1	1	1
8		1	1	1	1	1	1	0	1	1	1	1
9		1	NA	1	1	1	1	0	1	1	1	1
10		1	0	1	1	1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	70%	100%	100%	100%	100%	60%	100%	100%	100%	100%

Comments:
Blood sugar on intake not documented/not done; Baseline A1C NOT obtained within 30 days of arrival or within past 3 months; Prescription of aspirin NOT being documented as clinically iindicated; Degree of control (goal of HgbA1C < 8.0) NOT documented in treatment plan; NO strategy to attain diabetes control documented if HgbA1C was above goal.

Corrective Action Plan(s) (if appropriate):

Refresher training will be provided for providers and nurses on all the measures identfied. Training will be incooperated in daily reports.

Add additional 10 records if you fall below the threshold in the table to the right.

DIABETES - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11
11	b(6),(b)(7)(C)	1	1	1	1	1	1	0	0	0	1	1
12		1	1	1	1	1	1	1	NA	NA	NA	NA
13		1	1	1	1	1	1	0	0	NA	NA	NA
14		1	0	1	1	1	1	0	0	0	1	1
15		1	0	1	1	1	1	1	NA	NA	1	1
16		1	1	1	1	1	1	1	1	NA	1	1
17		1	0	1	1	1	1	0	0	0	1	1
18		1	1	1	1	1	1	0	0	NA	NA	NA
19		1	1	0	1	1	1	1	0	0	1	1
20		1	0	1	1	1	1	1	1	NA	1	1
	PERCENT COMPLIANCE	100%	60%	90%	100%	100%	100%	50%	40%	60%	80%	80%

Comments:
1tem # 13: No initial CH visit documented. Level of compliance FSBS (Intake)-65%; Aspirin-55%; A1C Goal- 70%; Strategy for A1C above goal-80%

Corrective Action Plan(s) (if appropriate):

ASTHMA (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT [redacted]
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with asthma during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with asthma for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? (100%)
2	Peak flow documented during health assessment (100%)
3	Peak flow documented during all chronic care visits? (100%)
4	Diagnosis listed in provider SOAP note (100%)
5	Diagnosis listed on problem list? (100%)
6	Treatment plan initiated in accordance with chronic care disease guidelines. (90%)
7	Patient education documented at each encounter? (100%)
8	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

ASTHMA

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
1	b(6),(b)(7)(C)	1	0	NA	1	1	1	1	1

ASTHMA - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
11	b(6),(b)(7)(C)	1	0	NA	1	1	1	1	1

2	[redacted]	1	1	0	1	1	1	1	1
3		1	0	NA	1	1	1	1	1
4		1	0	NA	1	1	1	1	1
5		1	0	NA	1	1	1	1	1
6		1	0	1	1	1	1	1	1
7		1	0	NA	1	1	1	1	1
8		1	0	NA	1	1	1	1	1
9		1	0	NA	1	1	1	1	1
10		1	0	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	10%	90%	100%	100%	100%	100%	100%

Comments:
- Peak flows are not being documented during health assessment and chronic care visits; Providers are not utilizing SFs (smart forms/Chronic care templates) and when utilized they are not completely filled out, thus leaving out vital information; 1- record showed no assessment completed within 2 days.

Corrective Action Plan(s) (if appropriate):
- Finding will be discussed during the providers' meeting, and measures would be made available to all provider for reference. Providers encounters will be reviewed weekly, and further training will be made available to providers if the need arises.

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

12	[redacted]	1	1	0	1	1	1	1	1
13		1	0	0	0	1	1	1	1
14		1	0	1	1	1	1	1	1
15		1	0	1	1	1	1	1	1
16		1	1	NA	1	1	1	1	1
17		1	0	NA	1	0	1	1	1
18		1	0	0	1	1	1	1	1
19		1	0	NA	1	1	1	1	1
20		0	NA	NA	NA	NA	NA	NA	NA
	PERCENT COMPLIANCE	90%	20%	40%	89%	89%	100%	100%	100%

89

Corrective Action Plan(s) (if appropriate):

HIV (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT [redacted]
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with HIV during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with HIV for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? (100%)
2	Documented HIV+ by laboratory or prior medical record? (95%)
3	CD4 and viral load obtained within 30 days of disease identification or recent CD4/viral load results obtained from prior record (recent is within the past 90 days)? (95%)
4	Antiretroviral treatment considered and documented? (100%)
5	Treatment plan initiated in accordance with chronic care disease guideline within two business days of illness identification. (95%)
6	Diagnosis listed in provider SOAP note (100%)
7	Diagnosis listed on problem list? (100%)
8	Was patient's care plan evaluated by a physician with experience in managing HIV patients within 30 days of HIV identification or admission to IHSC facility (if diagnosis already known)? (95%) This question was re-worded for FY 2016 for clarity
9	Was the patient seen by a medical provider at least every 90 days? (95%)
10	Was a PPD or IGRA performed within the last year? Note: if the patient has been positive in the past, an annual CXR is acceptable (95%)
11	If applicable, was the CXR completed or verified within 72 hours of health assessment as part of treatment plan? (95%)
12	Patient education documented at each encounter? (95%)
13	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

HIV

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
1	[redacted]	1	1	1	1	1	1	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1	1	1	1	1	1	1
3		1	1	1	1	1	1	1	1	1	1	1	1	1
4		1	1	1	1	1	1	1	1	1	1	1	1	1
5		1	1	1	1	1	1	1	1	1	1	1	1	1
6		1	1	1	1	1	1	1	1	1	1	1	1	1
7		1	1	1	1	1	1	1	1	0	1	1	1	1
8		0	1	1	1	0	1	1	1	NA	1	1	1	1
9		1	1	1	1	1	1	1	1	1	1	1	1	1
10		1	1	1	1	1	1	1	1	1	1	1	1	1
	Percent Compliance	90%	100%	100%	100%	90%	100%	100%	100%	90%	100%	100%	100%	

Comments:

1 record- (PE-C was not completed within 2 days); 1 Record- (Diagnosis not listed in provider note); 1- PPD or IGRA not performed within the last year

HIV - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
11	[redacted]	1	1	1	1	1	1	1	1	1	NA	1	1	1
12		1	1	1	1	1	1	1	1	1	1	1	1	1
13		1	1	1	1	1	1	1	1	NA	1	1	1	1
14		1	1	1	1	1	1	1	NA	1	1	1	1	1
15	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
16	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
17	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
18	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
19	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
20	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

Additional 4 records within compliance

Corrective Action Plan(s) (if appropriate):
HIV management protocol to be incooperated into providers' meeting

Corrective Action Plan(s) (if appropriate):

Add additional 10 records if you fall below the threshold in the table to the right.

TUBERCULOSIS (Detainees being treated for active tuberculosis disease) (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT (b)(
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with tuberculosis (TB) disease during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with TB disease for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	All patients evaluated for TB disease are tested for HIV (100%)
2	Pyrazinamide (PZA) and ethambutol (EMB) prescribed for no more than 60 days unless ordered by the advising physician (100%)
3	TB patients are seen at least monthly by a medical provider for follow-up visits (100%)
4	CXR is obtained 6-8 weeks after initiation of RIPE with comparison to previous CXR(s) (100%)
5	Initial cultures are performed with automatic sensitivity testing and culture and sensitivity results (if at least one culture is positive for M. tb) are reviewed (100%)
6	TB-CM visit note is completed at the time of diagnosis and updated with culture results, drug sensitivity test results (if culture positive), and final case classification within 90 days of diagnosis (100%)

TUBERCULOSIS (ESSENTIAL)

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6
1	(b)(6);(b)(7)(C)	1	1	1	1	1	1
2		1	1	1	1	1	1
3		1	1	1	NA	1	1
4		1	1	1	NA	1	NA
5		1	1	1	NA	1	1
6		1	1	1	NA	1	1
7		1	1	1	NA	1	NA
8		1	1	1	NA	1	1
9		1	1	1	NA	1	1
10		1	1	1	NA	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%

Comments:

Some detainees left before comparison CXR could be scheduled

Corrective Action Plan(s) (if appropriate):

N/A

TUBERCULOSIS (ESSENTIAL) - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

Add additional 10 records if you fall below the threshold in the table to the right.

SEIZURE DISORDER (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT (b)(6)
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with seizure disorder during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with seizure disorder for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? (100%)
2	2 Documented complete neurological history/assessment at physical examination? (100%)
3	Patient was referred to MLP or higher, if exam was completed by RN (95%)
4	Patient has treatment plan documented? (95%)
5	Diagnosis listed in provider SOAP note? (100%)
6	Diagnosis listed on problem list? (100%)
7	Baseline labs obtained (CBC, CHEM, lipid profile, UA & EKG) and reviewed within 30 days of illness identification? (100%)
8	Patient education documented at each encounter? (100%)
9	Language access: Use of translator, provider fluency in language or English speaking patient is documented? (100%)

SEIZURE DISORDER

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
1	[redacted]	1	1	1	1	1	1	NA	1	1
2		1	1	1	1	1	1	1	1	1
3		1	1	1	1	1	1	NA	1	1
4		1	1	1	1	1	1	NA	1	1
5		1	1	1	1	1	1	NA	1	1
6		1	1	1	1	1	1	NA	1	1
7		1	1	1	1	1	1	NA	1	1
8		1	1	1	1	1	1	1	1	1
9		1	1	1	1	1	1	NA	1	1
10		1	1	1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

#7: Detainee refused labs

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

SEIZURE DISORDER - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
11	N/A									
12										
13										
14										
15										
16										
17										
18										
19										
20										
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

SICK CALL (URGENT CARE) (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT [redacted]
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records from patients that have been seen for sick call during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of sick call encounters for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	Vital signs obtained and documented during assessment? (100%)
2	Weight was documented during assessment? (90%)
3	A thorough pain assessment (intensity, duration, quality, better/worse, etc.) was documented during assessment? (100%)
4	Treatment in accordance with nursing guidelines? (100%)
5	If pediatric patient, were pediatric pain guidelines followed? (90%)
6	If appropriate, patient was referred to a higher level of care? (if not appropriate, Enter as N/A) (95%)
7	Patient education documented at each encounter? (100%)
8	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

SICK CALL (URGENT CARE)

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
1	[redacted]	1	1	1	1	NA	1	1	1
2		1	1	1	1	NA	NA	1	1
3		1	1	1	1	NA	NA	1	1
4		1	1	1	1	NA	NA	1	1

SICK CALL (URGENT CARE) - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
11	N/A								
12									
13									
14									

5	(b)(6),(b)(7)(C)	1	1	1	1	NA	NA	1	1
6		1	1	1	1	NA	NA	1	1
7		1	1	1	1	NA	NA	1	1
8		1	1	1	1	NA	1	1	1
9		1	1	1	1	NA	1	1	1
10		1	1	1	1	NA	NA	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%

Comments:
Severity of pain on the Pain Template does not match the that on the VS Chart

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

15									
16									
17									
18									
19									
20									
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

MENTAL ILLNESS WITH PSYCHOTROPIC MEDICATIONS (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: (b)(6),(b)(7)(C)
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with mental illness who take psychotropic medications during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with mental illness and prescribed psychotropics during the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was a BH referral made in a timely manner (within 72 hours of intake or identification)? (100%)
2	Diagnosis listed by behavioral health provider in encounter note (100%)
3	Diagnosis listed on problem list? (100%)
4	If patient takes psychotropic medication, psychotropic medication consent (special consent form) signed for the drug ordered? (100%)
5	Clinical assessment, treatment, and follow up plan documented? (100%)
6	For patients on antipsychotic medication, was there an AIMS (Abnormal Involuntary Movement Scale) test performed? (100%) (physician, MLP, RN can conduct an AIMS test)
7	Was appropriate lab monitoring ordered depending on the psychotropic drug? (100%)

MENTAL ILLNESS WITH PSYCHOTROPIC MEDICATIONS

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	(b)(6),(b)(7)(C)	1	1	1	1	1	NA	NA
2		1	1	1	1	1	1	1
3		1	1	1	1	1	NA	NA
4		1	1	1	1	1	NA	NA
5		1	1	1	1	1	1	1
6		1	1	1	1	1	NA	NA
7		1	1	1	1	1	1	1
8		1	1	1	1	1	1	1
9		1	1	1	1	1	NA	NA
10		1	1	1	1	1	NA	NA
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%

Comments:
None

Corrective Action Plan(s) (if appropriate):
N/A

Add additional 10 records if you fall below the threshold in the table to the right.

MENTAL ILLNESS WITH PSYCHOTROPIC MEDICATIONS - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

DENTAL CARE (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: CAPT (b)(6)
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: A dentist, dental hygienist, RN, mid-level provider or physician will review appropriate number (see page 1) of records from patients seen by a dentist for treatment within the designated time frame.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

If there are not enough medical records to select the required number of records to review, 100% review will be required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was dental (oral) screening completed and documented within 14 days of arrival to facility (adults)? ***oral screening includes visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist? (100%)
2	Was dental (oral) screening completed and documented within 7 days of arrival to facility (children)? (100%)
3	If applicable, was patient evaluated within 48 hours of referral? (100%)
4	Does clinical note describe findings, diagnosis/assessment, treatment plans? (100%)
5	If applicable, patient scheduled for follow-up treatment as recommended? (100%)
6	Was the oral examination completed by a dentist or scheduled within 12 months of arrival to facility for adults? (100%) - oral examination by a dentist includes taking or reviewing the patient's oral history, an oral health and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral cavity.
7	Was the oral examination completed by a dentist or scheduled within 60 business days of arrival to facility for children? (100%)

DENTAL CARE

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	(b)(6),(b)(7)(C)	1	NA	1	1	1	1	NA
2		1	NA	1	1	1	1	NA
3		1	NA	1	1	1	1	NA
4		1	NA	1	1	1	1	NA
5		1	NA	1	1	1	1	NA
6		1	NA	1	1	1	1	NA
7		1	NA	1	1	1	1	NA
8		1	NA	1	1	1	1	NA
9		1	NA	1	1	1	1	NA
10		1	NA	1	1	1	1	NA
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

DENTAL CARE - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
11	N/A							
12								
13								
14								
15								
16								
17								
18								
19								
20								
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

CONTINUITY OF CARE REVIEW (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: LT (b)(6)
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: Health staff (any IHSC staff) will review appropriate number (see page 1) of randomly selected records of patients who went to the Emergency Department during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of applicable medical records for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	Was a discharge summary/instructions requested or present? (100%) – (was a discharge summary/instructions received when the patient returned from the hospital?)
2	Was there a note from the IHSC provider detailing the reason the detainee was sent to the ED? (100%)
3	Was a note entered in the medical record upon the detainee's return to the facility listing the ED/hospital's recommended plan of care? (100%)
4	Did the provider follow the ED/hospital's recommended plan of care? (100%)
5	Upon return from ED, was the patient/parent educated about diagnosis, medications (if applicable) and treatment plan? (100%)
6	Is there documentation acknowledging patient/parent understands treatment plan? (100%)
7	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

CONTINUITY OF CARE								
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	[redacted]	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1
3		1	1	1	1	1	1	1
4		1	1	1	1	1	1	1
5		1	1	1	1	1	1	1
6		1	1	1	1	1	1	1
7		1	1	1	1	1	1	1
8		1	1	1	1	1	1	1
9		1	1	1	1	1	1	1
10		1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

CONTINUITY OF CARE - Additional Records If First 10 Are Below Threshold								
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

REASONABLE ACCOMMODATIONS SELF-ASSESSMENT

Facility: Stewart Detention Center
Reviewer: LCDR [redacted]
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: Obtain the information from the HSA's Reasonable Accommodation Self-Assessment Tool.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

REASONABLE ACCOMMODATIONS SELF-ASSESSMENT	
POLICY, PROCEDURES, and TRAINING	YES (1) or NO (0)
1. Procedures are in place to ensure detainees with disabilities are informed of and have an equal opportunity to request and obtain health services.	1
2. IHSC staff has received initial training on interacting with individuals with disabilities and individuals requiring reasonable accommodations, and annually thereafter.	1
3. Written evacuation procedures and emergency communications are in place in the clinic for individuals with disabilities.	1
4. Procedures have been established to ensure that accessible features (within the IHSC-staffed facilities) are maintained. (Enter N/A if non-applicable)	1
PHYSICAL ACCESSIBILITY	
5. The facility provides reasonable accommodation access for individuals within the Health Unit.	1
COMMUNICATION	
6. The IHSC clinic has access to sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities.	1
PERCENT COMPLIANCE:	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

TREATMENT OF DISABILITIES

Facility: Stewart Detention Center
Reviewer: LT [redacted]
Quarter/Fiscal Year: 4th Quarter 2017

PURPOSE: To assess care of detainees who need accommodation for their disabilities. An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.
(see http://www.ada.gov/q%26aeng02.htm , accessed January 20, 2012).

An RN, MLP or physician can review.

SOURCE: Facility logs or tour of facility and interviews with detainees who need accommodation.

Sample: 10 detainees within the population who have a disability that requires special medical treatment. Determine through medical record examination if appropriate treatment and accommodation was given.

Instructions: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations? (100%)
2	Was the detainee assessed to determine if the disability limits one or more major life activity (as defined by ADA: basic activities that the average person in the general population can perform with little or no difficulty, such as (but not limited to) caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, concentrating, thinking, interacting with others and working. A major life activity can also include the operation of a major bodily function)?
3	Were appropriate special orders entered (e.g., lower bunk, assistive device, meal, etc.)? (100%)
4	Was ADL assistance provided? (100%)

TREATMENT OF DISABILITIES					
Record	216	Measure 1	Measure 2	Measure 3	Measure 4
1	b(6)(b) b(7)(C)	1	1	1	1
2		1	1	1	NA
3		1	1	1	NA
4		1	1	1	NA
5		1	1	1	NA
6		1	1	1	NA
7		1	1	1	1
8		1	1	1	NA
9		1	1	1	NA
10		1	1	1	NA
	PERCENT COMPLIANCE	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

Facility: Stewart Detention Center
Reviewer: LT b(6)(b)
Quarter/Fiscal Year: 4th Quarter 2017

PURPOSE: To assess timeliness of off-site diagnostic services and specialty care.

SOURCE: Statistics

MLP or physician can review.

SAMPLE: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

INSTRUCTIONS: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Documented time urgency on order? (90%)
2	Accomplished within 45 days of order or within ordered timeframe, e.g., "return in 90 days"? (100%)
3	Documented re-evaluation of patient for deterioration each 30 days in excess of time urgency on order? (90%)
4	Clinician acknowledgement and report in medical record within 7 days? (90%)
5	Detainee informed of results or reason for delay if not scheduled? (90%)

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS							
Record	Alien #	Clinic	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5
1	b(6)(b) b(7)(C)	Radiology	1	1	1	1	NA

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS - Additional Records If First 10 Are Below Threshold							
Record	Alien #	Clinic	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5
11							

2	(b)(6),(b)(7)(C)	Dialysis	1	1	1	1	NA
3		Surgery	1	1	1	1	NA
4		Podiatry	1	1	1	1	NA
5		Surgery	1	1	1	1	NA
6		Optometry	1	1	1	1	NA
7		Surgery	1	1	1	1	NA
8		gastroenterology	1	1	1	1	NA
9		Surgery	1	1	1	1	NA
10		Orthopedics	1	1	1	1	NA
		PERCENT COMPLIANCE	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

12							
13							
14							
15							
16							
17							
18							
19							
20							
		PERCENT COMPLIANCE	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

LABORATORY AND DIAGNOSTICS

Facility: Stewart Detention Center
Reviewer: LT (b)(6)
Quarter/Fiscal Year: 4th Quarter 2017

PURPOSE: To assess timeliness, continuity, and coordination of care.

Source: Laboratory log.

RN, MLP or physician can review.

Sample: 10 most recent orders for acute labs, not including routine testing for detainees with chronic illness.

Instructions: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Up to date certification for CLIA-waived testing accessible? (100%)
2	Documentation of applicable staff training for performing CLIA-waived tests? (100%)
3	Blood drawn or test done within 1 business day of ordered date? (100%)
4	Results received within 24 hours or as appropriate? (100%)
5	Clinician acknowledgment? (100%)
6	Appropriate clinical response? (100%)
7	Detainee informed of results; if not, reason documented in medical record? (100%)

LABORATORY AND DIAGNOSTICS

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	(b)(6),(b)(7)(C)	1	1	NA	1	1	1	1
2		1	1	NA	1	1	1	1
3		1	1	NA	1	1	1	1
4		1	1	NA	1	1	1	1
5		1	1	1	1	1	1	1
6								
7								
8								
9								
10								
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

LABORATORY AND DIAGNOSTICS - Additional Records If First 10 Are Below Threshold

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

CREDENTIALING

Facility: Stewart Detention Center

Reviewer: CAPT [redacted]
Quarter/Fiscal Year: 4th Quarter 2017

Purpose: To assess credentials of all health care professionals, ensuring they are legally qualified to provide services consistent with licensure, certification, and registration requirements of the practicing jurisdiction.

Source: Up to 10 fields for each of all licensed health care professionals.

HSA or AHSA will review

Instructions: Enter as "1" for yes, "0" for no, and "NA1" for not applicable. Do not leave any area blank.

Sample: 10 chosen at random

Item #	Measure
1	Documentation of primary source validation (e.g., internet) of current license, certification or registrations for all applicable licensed professionals (100%)
2	Validation of DEA for physicians, psychiatrists, and dentists? (100%)
3	Current CPR certificate (100%)
4	Documentation of inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank (NPDB) (100%)

CREDENTIALING

Record	Employee	Measure 1	Measure 2	Measure 3	Measure 4
1	NP	1	NA	1	1
2	NP	1	NA	1	1
3	NP	1	NA	1	1
4	PA	1	NA	1	1
5	DO	1	1	1	1
6	RN	1	NA	1	1
7	MD	1	1	1	1
8	NP	1	NA	1	1
9	RN	1	NA	1	1
10	LPN	1	NA	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

MORTALITY REVIEW

Facility: Stewart Detention Center
Reviewer: [redacted]
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS: To determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

SOURCE: Minutes, notes, medical records, emergency response, and other pertinent documents.

MLP or physician will review.

INSTRUCTIONS: Enter as "1" for yes, "0" for no, and "NA" for not applicable. Do not leave any area blank.

SAMPLE: All in-custody deaths, including those in hospital, within the past quarter. If applicable, most of the information can be requested through the HAS or designee.

ITEM #	MEASURE
1	Multidisciplinary mortality review (clinical, administrative) within 30 calendar days of death (this review is completed by HQ. Request information from HSA)? (100%)
2	Follow-up review when autopsy and toxicology reports are available? (100%)
3	Assessment as to whether the medical response was appropriate on the day of death or transfer to the hospital? (100%)
4	Assessment as to whether earlier intervention was possible and whether that would have changed the outcome? (100%)
5	Analysis of ways to improve patient care, independent of the cause of death or RCA completed? (100%)
6	For suicides only, was there a psychological autopsy ordered/completed? (100%)
7	Was the involved staff informed of the clinical mortality review and administrative findings? (100%)
8	Was treating staff informed of the clinical mortality review and administrative findings? (100%)

DEFINITION:
Clinical mortality review is an assessment of clinical care provided and the circumstances leading up to the death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved. (This information is collected by the HSA, IHSC Compliance Investigations and Risk Management)

Administrative morality review is an assessment of correctional and emergency response actions surrounding the detainee's death. Its purpose is to identify areas where facility operations, policies and procedures can be improved. (This information is collected by the HSA, IHSC Compliance Investigations and Risk Management)

MORTALITY REVIEW

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
1	NA	NA	NA	NA	NA	NA	NA	NA	NA
2									
3									
4									
5									
6									
7									
8									
9									
10									
	PERCENT COMPLIANCE								

Comments: NA

Corrective Action Plan(s) (if appropriate): NA

MEDICAL RECORDKEEPING PRACTICES

Facility: Stewart Detention Center
Reviewer: [redacted]
Quarter/Fiscal Year: 4th Quarter 2017

INSTRUCTIONS:
- This worksheet should be filled out following the performance-based reviews.
- Put a "1" in the appropriate column (Yes, Partial, No, or N/A) for each measure.
  - For example, if all 10 records comply with "identifying information", then a 1 should be placed in the YES column.
  - If only some of the records comply, a 1 should be placed in the PARTIAL column.
  - If none comply, a 1 should be placed in the NO column.
  - Only put a 1 in ONE of the 4 columns (Yes/Partial/No/NA) for each criteria.
- For all answers that are "partial compliance" or "non-compliance," the reviewer should write a comment.
  - For example, if most of the progress notes are legible, but one or two practitioners' notes are barely legible, the appropriate comment would be "Dr. XX.s notes are not legible."
- Reviewer can be any health care provider.

SAMPLE: 10 Records reviewed on detainees with chronic disease.

MEDICAL RECORDKEEPING PRACTICES

		YES	PARTIAL	NO	N/A	COMMENTS
1	Identifying information (100%)	1				
2	Current problem list (100%)	1				
3	Receiving screen and health assessment forms (100%)	1				
4	Progress notes (100%)	1				
5	Clinician orders for medication, signed (100%)	1				
6	MARs (100%)	1				
7	Lab and diagnostic reports (100%)	1				
8	Flow sheets (100%)	1				
9	Consent, refusal, and release of information forms (100%)	1				
10	Results of specialty consultations and referrals (100%)	1				
11	Discharge summaries from ED and hospitalizations (100%)	1				
12	Special needs treatment plan, where applicable (100%)	1				
13	Immunizations records, where applicable (100%)	1				
14	Date and time of each encounter (100%)	1				
15	Integrated medical, dental, and mental health record (100%)	1				
16	Timely filing, within 72 hours (100%)	1				
17	Consolidated medical record (100%)	1				
18	Content organized for easy retrieval (100%)	1				
19	EHR password protected, by individual (100%)	1				
20	Integrated health information with EHR, where applicable (100%)	1				
	PERCENT COMPLIANCE	100%	0%	0%	0%	

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Evaluate an additional 10 records if you fall below the threshold in parentheses. Follow the instructions above the table to include the results for the additional 10 records in the appropriate columns of the table.

Workbook Protection

(b)(7)(E)

Password for protected sheets: (b)(7)(E)

IHSC DENTAL PROCESS STUDY

Process studies examine the efficiency of various health care **procedures**.

Facility Conducting Study: _____Stewart Detention Center_____

Date submitted to IHSC HQ PI Coordinator: ____6/7/2016___(CAPT [redacted])

Step 1: Decide what to study.
Step 1: Comprehensive oral exams completed/offered within 1 year of custody per IHSC policy and per ACA and NCCHC guidelines.
Step 2: Decide how to measure efficiency or effectiveness.
Step 2: Review eCW records to confirm comprehensive oral exams were completed/offered within 1 year of custody.

Step 3: Decide on the data source.
Step 3: Records for dental patients will be reviewed in eCW. ICE roster will be utilized to find patients with 1 year or greater in ICE custody. Will review date of intake. Will review date comprehensive oral exam was completed or offered.
Step 4: Decide on the timeframe to review
Step 4: A retrospective study will be completed reviewing records from patients with 1 year or greater in custody.
Step 5: Decide on sample size.
Step 5: Patients with 1 year or greater in custody.
Step 6: Decide on the sampling method
Step 6: Entire cohort

Step 7: Decide on the thresholds for compliance.
Step 7: 95% compliance
Step 8: Decide who is going to conduct the study.
Step 8: Dentist with support of Dental Assistant for gathering data.
Step 9: Conduct the study, analyze the results, and determine the appropriate corrective action.

Step 9: Study reveals 100% of patients in custody for 1 year June 2016 received or were offered a comprehensive oral exam prior to 1 year. Records were reviewed for 34 patients in custody for 1 year. All 34 patients were offered a comprehensive oral exam prior to 1 year in custody. Comprehensive oral exams were completed for 33 patients; refusals were received from 1 patients. All patients still received the dental exam prior to one year in custody, since the dental staff uses two methods to ensure scheduling in the appropriate timeframe. Dental staff uses eCW appointment logs and a separate ICE roster to identify patients nearing one year in custody. This secondary verification process is effective in ensuring all patients are seen for their required annual dental exam. No change to the current process is indicated. Dental will continue scheduling the annual dental exams based on the eCW appointment logs and the ICE facility roster.

Step 10: Implement the corrective action plan.
Step 10: Corrective action plan not indicated.
Step 11: Repeat the study after some time has elapsed to determine whether the corrective action plan resulted in improvements.
Repeat as necessary if future concerns are identified.
Step 12: If no improvement, do a more focused review of the steps in the process.
NA

Process STUDY
Stewart Detention Center

Process Study

Facility Conducting Study: Stewart Detention Center

Date submitted to DIHS HQ PI Coordinator:

Step 1: Decide what to study. In preparation for the 2016 PBNDS audit at Stewart Detention Center (SDC) it was noted that several charts in eCW did not contain either a Psychotropic Consent form or a consent form to receive tele-health. The purpose of this study is to verify compliance with IHSC policy as it pertains to psychotropic and tele-health consent forms.
Step 2: Decide how to measure efficiency or effectiveness. - Generate a Drug Utilization Review (DUR) from CIPS to identify all detainees prescribed psychotropic medications and received tele-health for the time period in question. Review all records in eCW of the detainees identified from the DUR.

Step 3: Decide on the data source. - DUR generated in CIPS. Chart review of records in eCW.
Step 4: Decide on the timeframe to review - Retrospective study from May 2015 to April 2016
Step 5: Decide on sample size. - All records identified by DUR from May 2015 to April 2016.
Step 6: Decide on the sampling method. No sampling method, report will collect data from all records identified from DUR.

Step 7: Decide on the thresholds for compliance. 100% compliance as indicated by IHSC standards.
Step 8: Decide who is going to conduct the study. - Study conducted by CDR [redacted] QI Coordinator SDC and LCDR [redacted] Asst. QI Coordinator.
Step 9: Conduct the study, analyze the results, and determine the appropriate corrective action. A DUR was generated that included all detainees that were prescribed psychotropic medications from May 2015 – April 2016. In total 275 detainees were identified for the time period. Of the 275 detainees 5 did not have a Tele-health consent form and 17 did not have a Psychotropic consent form. Corrective Action: - Informed HSA CAPT [redacted] and aHSA LCDR [redacted] of results of the study. - Informed Head of Behavioral Health, CDR [redacted] of the results of the study. - All detainees identified at SDC who did not have the appropriate Consent Form were brought to IHSC medical to sign the proper consent form. - Random 30 day check of all new behavioral health patients to ensure compliance.

Step 10: Implement the corrective action plan. Corrective action plan implemented May 2016

Step 11: Repeat the study after some time has elapsed to determine whether the corrective action plan resulted in improvements. Specific Step 11 Example: Follow-up conducted May 31th, 2016. 30 day review - 6/10/16 – Five additional charts reviewed, all compliant. No further corrective action warranted.
Step 12: If no improvement, do a more focused review of the steps in the process. Specific Step 12 Example: .
No further actions required, will continue to monitor through completion of quarterly PI assessment tool.

ICE HEALTH SERVICE CORPS (IHSC) - CONTINUOUS QUALITY IMPROVEMENT AUDIT TOOL - FY 2016

You will report EVERY quarter on <u>ALL MEASURES</u> that follow. There are 28 measures in total.

- Medication Errors
    - Medication Administration Errors
    - Prescribing/Ordering Errors
    - Pharmacy Order Errors
    - Self-administered medications, continuity of medication and medication refusals

- Grievances
- Suicide Watch
- Hunger Strikes

For each of these components, you will review <u>10 charts</u> (unless findings fall below the threshold established [thresholds are listed after each item] – then you must review 10 additional records). NOTE: If there are less than 10 charts, then review 100% of those charts that are applicable.

- Pregnancy Audit
- Medical Housing Unit
- Screening and Health Assessment
- Hypertension
- Diabetes
- Asthma
- HIV
- Tuberculosis
- Seizure Disorder
- Sick Call/Urgent Care
- Mental Illness with Psychotropic Medication
- Dental Care
- Continuity of Care
- Reasonable Accommodations
- Treatment of Disability
- Medication Administration Records
- Continuity of Medication
- Medication Refusal
- Diagnostic Services and Specialty Care Access
- Laboratory and Diagnostics
- Credentialing
- Mortality Review
- Medical Recordkeeping Practices

THRESHOLDS FOR COMPLIANCE: Each indicator has a percentage of compliance required (written next to it). <u>If you fall below this threshold for compliance, you must submit a corrective action plan for it.</u> The corrective action plan should be written in the section following the data.

MEDICATIONS (ESSENTIAL)

Instructions: Place the number if medication errors (from incident reports) in the column marked "numbers". If none, put "0". If not applicable, put "N/A". Do not leave any blank.

Medication Administration Errors

	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong medications given	1	1
2. Number of wrong patients receiving medication	0	0
3. Number of medications given at wrong time	0	0
4. Number of medications missed	4	4
5. Number of medications administered via wrong route	0	0
6. Number of wrong doses given	1	1
7. Number of transcription errors	0	0
8. Number of expired prescriptions given	0	0
9. Other- meds on both pill line and to KOP	8	8
TOTAL NUMBER FROM 1-9:	0	0

Prescribing/Ordering Errors

	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong patients receiving medication	0	0
2. Number of wrong drug - indication	0	0
3. Number of wrong drug - allergy	0	0
4. Number of wrong drug – drug interaction	0	0
5. Number of wrong doses	0	0
6. Number of wrong dosing schedules	0	0
7. Number of orders written incorrectly	0	0
8. Number of medication orders not forwarded to pharmacy	1	1
9. Other	0	0
TOTAL NUMBER FROM 1-9:	0	0

	Percentage/Whole #	Yes/No/NA
1. Estimate % of patients on self-administered medication (check with pharmacy) (enter percentage)	35%	N/A
2. If detainee requires continuation of medication, was medication ordered within 24 hours from completion of intake screening? (Review 10 random medical records)	100%	N/A
3. Average lapse time from order to first dose of medication, if greater than 24 hours?	N/A	Only extends beyond 24 hours if detainee seen after clinic hours on Friday evenings or on the weekend.
4. Number of refusals/no shows (on 3 consecutive days or 3 consecutive doses and/or 50% of doses missed within 7 days)	N/A	N/A
5. Other	N/A	N/A
TOTAL NUMBER FROM 1-5:	2	N/A

Pharmacy Errors

	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong patients	0	0
2. Number of wrong medications	0	0
3. Number of wrong doses	0	0
4. Number of incorrect labels	1	1
5. Number of wrong routes	0	0
6. Number of MAR errors (misprinted, medication missing)	0	0
TOTAL NUMBER FROM QUESTIONS 1-6:	1	1

GRIEVANCES (IMPORTANT)

Instructions: Obtain the numbers from grievance logs.

	Number
1. Number of grievances received	12
2. Number of grievances addressed* within 5 business days * Designated medical staff shall act on the grievances within 5 working days of receipt and provide the detainee with a written response of the decision and the rationale.	11
3. Number of grievances related to access to care	6
4. Number of grievances related to quality of care	6

Comments: One grievance busted suspense due to detainee being hospitalized.

Corrective Action Plan(s) (if appropriate): None needed.

SUICIDE WATCH (ESSENTIAL)

Instructions: Obtain the numbers from intake screenings, suicide watch logs and medical records.

	Number
1. Total number of detainees on suicide watch during specified timeframe (for suicidal ideation, actions)	1
2. Number of detainees (from number above) on suicide watch during specified time frame who made an actual suicide attempt	0
3. Number of incident reports submitted (required for detainees with suicidal attempt)	1
4. Number of detainees on suicide watch who were evaluated by behavioral health professionals within 24 hours, unless emergent (in which case the evaluation should be immediate)	1
5. Number of detainees on suicide watch (from number above) who were seen previously by IHSC for mental health issues.	1
6. Number of detainees on suicide watch with daily evaluations done by qualified medical staff	1
7. Number of detainees on suicide watch with appropriate documentation (i.e. 15 minute and 8 hour documentation)	1
8. Number of detainees on suicide watch that received follow up post/after discharge from suicide watch at interval consistent with the level of acuity (PBNDS)	1

Comments: None.

Corrective Action Plan(s) (if appropriate): No further actions warranted.

HUNGER STRIKES (ESSENTIAL)

Instructions: Obtain the numbers from hunger strike logs and medical records.

	Number
1. Number of detainees on hunger strikes	57
2. Number of detainees requiring medical intervention (intravenous therapy) ON SITE (not those off-site)	0
3. Number of detainees requiring medical intervention (intravenous therapy) ON SITE(not those off-site) for whom an incident report was submitted	0
4. Number of detainees on hunger strike with complete documentation (daily vital signs, daily weights, intake and output)	57
5. Number of detainees on hunger strikes with provider evaluation documented	57
6. Number of detainees on hunger strike requiring court-ordered force-feeding on site	0
7. Number of detainees on hunger strike requiring court-ordered force-feeding in hospital	0

Comments: None.

Corrective Action Plan(s) (if appropriate): No further actions warranted.

PREGNANCY AUDIT (ESSENTIAL)

Facility: SDC **Quarter/Fiscal Year: 1st/2017**

Reviewer: N/A

Instructions: A health care provider will review 100% of the charts of the pregnant patients during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

Sample size: 100%

Item #	Measure
1	Was an OB-GYN consult ordered and the scheduled appointment time documented within 7 days of identification of condition? (Not necessarily seen within 7 days) **(100%)**
2	Prenatal vitamins prescribed? **(100%)**
3	Proper diet ordered? **(100%)**
4	Patient education documented at each encounter? **(100%)**
5	Records reviewed by provider after OB appointment? **(100%)**
6	Appropriate labs (consideration for HIV, STI, and viral hepatitis) ordered if not obtained from OB-GYN? **(100%)**

Record	Alien #	1	2	3	4	5	6
1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	N/A	N/A	N/A	N/A	N/A	N/A	N/A
6	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7	N/A	N/A	N/A	N/A	N/A	N/A	N/A
8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
9	N/A	N/A	N/A	N/A	N/A	N/A	N/A
10	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PERCENTAGE		N/A	N/A	N/A	N/A	N/A	N/A

Comments: Male only facility
Corrective Action Plan(s) (if appropriate): N/A

MEDICAL HOUSING UNIT REVIEW (ESSENTIAL)

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: LT [redacted] **RN**

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of patients who were admitted to the MHU during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of MHU patients for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Admitting history/current diagnosis or issues documented on the MHU progress note (to be completed by a physician/MLP or appropriate clinician according to scope of practice)? **(100%)**
2	Appropriate exam documented relevant to the reason for the MHU stay? – e.g. dental, medical, or behavioral health exam? **(100%)**
3	Provider rounds documented as noted in the treatment plan, if applicable **(90%)**
4	Treatment plan includes specific instructions for nursing and appropriate precautions or interventions for infectious disease? **(90%)**
5	Nursing care plan present? **(90%)**
6	Nursing care follow-up documented? **(100%)**
7	Nursing progress notes present for each shift? **(100%)**
8	24 hour chart review indicated with signature, date and time of review? **(90%)**
9	Discharge from MHU documented, if applicable **(100%)**
10	Language Access: Use of translator, provider fluency in language, or English-speaking detainee is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8	9	10
1	[redacted]	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
2		Y	Y	Y	Y	N	Y	Y	Y	Y	Y
3		Y	Y	Y	Y	Y	Y	Y	N	Y	Y
4		Y	Y	Y	Y	Y	Y	Y	N	Y	Y
5		Y	Y	Y	Y	Y	Y	Y	N	Y	Y
6		Y	Y	Y	Y	Y	Y	N	Y	Y	Y
7		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8		Y	Y	Y	Y	Y	Y	Y	N	Y	Y
9		Y	Y	Y	Y	N	Y	Y	N	Y	Y
10		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
PERCENTAGE		100%	100%	100%	100%	80%	100%	90%	40%	100%	100%

Record	Alien #	1	2	3	4	5	6	7	8	9	10
1	[redacted]	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
2		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
3		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

4	[redacted]	Y	Y	Y	Y	N	Y	Y	N	Y	Y
5		Y	Y	Y	Y	N	Y	Y	N	Y	Y
6		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
7		Y	Y	Y	Y	N	Y	Y	Y	Y	Y
8		Y	Y	Y	Y	N	Y	Y	N	Y	Y
9		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
PERCENTAGE		100%	100%	100%	100%	50%	100%	100%	70%	100%	100%

Comments: Deficiencies in the MHU were noted to nursing care plans (#5), nursing progress notes at each shift (#7) documentation of use of interpreter at each visit and (#8) 24 hour chart review indicated with signature, date and time of review. Upon review of second sample of charts, area #7 increased in compliance but areas #5 and #8 remained deficient.

Corrective Action Plan(s) (if appropriate): Notified HSA, AHSA, and Nurse Manager of results of the audit. Results of audit to be reviewed at next scheduled staff meeting and nursing morning report. Will re-educate staff verbally and with training slide that will include requirements for MHU review in nursing manual as a reference.

SCREENING AND HEALTH ASSESSMENT (ESSENTIAL)

Facility: SDC Quarter/Fiscal Year: 1st/2017

Reviewer: LT Okoli, RN

Instructions: An RN, MLP, physician or clinical pharmacist will review the appropriate number (see page 1) of randomly selected records for patients that have been at the facility for more than two weeks during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

Sample size: See Page 1 of this document

Item # **Measure**

- Initial screening completed within 12 hours of admission to facility? **(100%)**
- All required areas of the intake template in eCW are completed? **(100%)**
- TB screening completed during medical intake if applicable (PPD or CXR)? **(100%)**
- PPD read within 48-72 hours? (N/A if CXR performed) **(100%)**
- TB clearance properly documented? **(100%)**
- Was there timely (NLT 2 working days after identification) follow-up for significant findings of acute and chronic conditions? (100%) (A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health) **(100%)**
- Was health assessment completed within 14 days? **(100%)**
- Was health assessment completed within 7 days for children? (Family Residential Centers) **(100%)**
- Was health assessment completed for patients with chronic illnesses within two working days? **(100%)**
- Health assessment (health history and hands-on physical examination) completed by licensed physician/PA/NP/RN (if completed by RN, must have documented training) **(100%)**
- If applicable, documentation of transfer summary reviewed within 12 hours? **(100%)**
- Patient education documented at each encounter? **(100%)**
- Language access: Use of translator, provider fluency in language, or English-speaking patient is documented. **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8	9	10	11	12	13
1	[redacted]	Y	Y	Y	N/A	Y	N/A	Y	N/A	N/A	Y	Y	Y	Y
2		Y	Y	Y	N/A	Y	N/A	Y	N/A	N/A	Y	Y	Y	Y
3		Y	Y	Y	N/A	Y	N/A	Y	N/A	N/A	Y	Y	Y	Y
4		Y	Y	Y	N/A	Y	N/A	Y	N/A	N/A	Y	Y	Y	Y
5		Y	Y	Y	N/A	Y	Y	Y	N/A	Y	Y	Y	Y	Y
6		Y	Y	Y	N/A	Y	Y	Y	N/A	Y	Y	Y	Y	Y
7		Y	Y	Y	N/A	Y	Y	Y	N/A	N/A	Y	Y	Y	Y
8		Y	Y	Y	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	Y	Y
9		Y	Y	Y	N/A	Y	N/A	N/A	N/A	N/A	N/A	Y	Y	Y
10		Y	Y	Y	N/A	Y	Y	Y	N/A	Y	Y	Y	Y	Y
PERCENTAGE		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Add additional 10 records if you fall below the threshold.

Comments: No deficiencies noted.

Corrective Action Plan(s) (if appropriate): None required.

HYPERTENSION (ESSENTIAL)

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: [redacted]

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with hypertension during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with hypertension for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Blood pressure reading documented at intake? **(100%)**
2	Patient seen by medical provider within two business days of illness identification **(100%)**
3	Patient was referred to MLP or higher, if exam was completed by RN **(95%)**
4	Patient has treatment plan documented? **(95%)**
5	Diagnosis listed in provider SOAP note? **(100%)**
6.	Diagnosis listed on problem list? **(100%)**
7	Baseline labs obtained (CBC, CHEM, lipid profile, UA & EKG) and reviewed within 30 days of illness identification? **(100%)**
8	Patient education documented at each encounter? **(100%)**
9	Language access: Use of translator, provider fluency in language or English speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8	9
1	[redacted]	Y	Y	N/A	Y	Y	Y	Y	Y	Y
2		Y	Y	N/A	Y	Y	Y	Y	Y	Y
3		Y	Y	N/A	Y	Y	Y	Y	Y	Y
4		Y	Y	N/A	Y	Y	Y	Y	Y	Y

5	[redacted]	Y	Y	N/A	Y	Y	Y	Y	Y	Y
6		Y	Y	N/A	Y	Y	Y	Y	Y	Y
7		Y	Y	N/A	Y	Y	Y	Y	Y	Y
8		Y	Y	N/A	Y	Y	Y	Y	Y	Y
9		Y	Y	N/A	Y	Y	Y	Y	Y	Y
10		Y	Y	N/A	Y	Y	Y	Y	Y	Y
PERCENTAGE		100%	100%	100%	100%	100%	100%	100%	100%	100%

Add additional 10 records if you fall below the threshold.

Comments: All assessed areas above compliance levels.

Corrective Action Plan(s) (if appropriate): None at this time.

DIABETES (ESSENTIAL)

Facility: **SDC** **Quarter/Fiscal Year:** **1st/2017**
Reviewer: [redacted] **RN**

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with diabetes during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with diabetes for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was PE-C completed within two business days if diabetes was identified at time of arrival? **(100%)**
2	Documented blood sugar on intake (if diabetes identified at intake) or documented reason for not testing e.g. detainee just ate food one hour ago? **(90%)**
3	Diagnosis listed in provider SOAP note **(100%)**
4	Diagnosis listed on problem list? **(100%)**
5	Baseline A1C obtained within 30 days of arrival or within past 3 months? **(100%)**
6	Baseline measurement of lipids within 30 days? (**100%)**
7	Documented prescription of aspirin, as clinically indicated? **(80%)**
8	Degree of control (goal of HgbA1C < 8.0) documented in treatment plan? **(90%)**
9	Was a strategy to attain diabetes control documented if HgbA1C was above goal? **(100%)**
10	Patient education documented at each encounter? (**100%)**
11	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8	9	10	11
1	[redacted]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2		Y	Y	Y	Y	Y	Y	N	N	N	Y	Y
3		Y	N	Y	Y	Y	Y	N	Y	Y	N	Y
4		Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
5		Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
6		Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y

7	[redacted]	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y
8		Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y
9		Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y
10		Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
PERCENTAGE		100%	70%	100%	100%	100%	100%	20%	70%	70%	90%	100%

Add additional 10 records if you fall below the threshold

Record	Alien #	1	2	3	4	5	6	7	8	9	10	11
1	[redacted]	Y	Y	Y	Y	Y	Y	Y	N	N/A	Y	Y
2		Y	N/A	Y	Y	Y	Y	Y	Y	N/A	Y	Y
3		Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
4		Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
5		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6		Y	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Y
7		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8		Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
9		Y	y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10		Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
PERCENTAGE		100%	100%	100%	100%	100%	100%	70%	90%	100%	90%	100%

Comments: On first audit set, several areas fell below compliance levels on this audit (#2, #7, #8, #9 and #10) fell out of prescribed compliance window. Upon audit of second set of charts, #7, #8 and #10 continued to pose as areas of non-compliance.

Corrective Action Plan(s) (if appropriate): Will discuss findings of audit with providers at the next scheduled provider meeting. Will suggest staff physician perform spot checks of 5 charts weekly over the next 3 weeks to verify compliance.

ASTHMA (ESSENTIAL)

Facility: SDC Quarter/Fiscal Year: 1st/2017
Reviewer: LT [redacted] **RN**

Instructions: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with asthma during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.
To RANDOMLY select, list out the total number of patients diagnosed with asthma for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? **(100%)**
2	Peak flow documented during health assessment **(100%)**
3	Peak flow documented during all chronic care visits? **(100%)**
4	Diagnosis listed in provider SOAP note **(100%)**
5	Diagnosis listed on problem list? **(100%)**
6	Treatment plan initiated in accordance with chronic care disease guidelines. **(90%)**
7	Patient education documented at each encounter? **(100%)**

8 Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8
1	[redacted]	Y	Y	Y	Y	Y	Y	Y	Y
2		Y	N	Y	Y	Y	Y	Y	Y
3		Y	Y	N	Y	Y	Y	Y	Y
4		Y	Y	Y	Y	Y	Y	Y	Y
5		Y	Y	N	Y	Y	Y	Y	Y
6		Y	Y	Y	Y	Y	Y	Y	Y
7		Y	Y	N	Y	Y	Y	Y	Y
8		Y	Y	N	Y	Y	Y	Y	Y
9		Y	Y	Y	Y	Y	Y	Y	Y
10		Y	Y	N	Y	Y	Y	Y	Y
PERCENTAGE		100%	90%	50%	100%	100%	100%	100%	100%

Add additional 10 records if you fall below the threshold.

Record	Alien #	1	2	3	4	5	6	7	8
1	[redacted]	Y	Y	N	Y	Y	Y	Y	Y
2		Y	N	N	Y	Y	Y	Y	Y
3		Y	Y	N/A	Y	Y	Y	Y	Y
4		Y	Y	N	Y	Y	Y	Y	Y
5		Y	Y	Y	Y	Y	Y	Y	Y
6		Y	Y	N	Y	Y	Y	Y	Y
7		Y	Y	Y	Y	Y	Y	Y	Y
8		Y	N	N	Y	Y	Y	Y	Y
9		Y	N	N/A	Y	Y	Y	Y	Y
10		Y	Y	N/A	Y	Y	Y	Y	Y
PERCENTAGE		100%	70%	50%	100%	100%	100%	100%	100%

Comments: Issues with peak flow being documented during health care assessments and chronic care visits as well as documentation of patient education revealed during this audit were consistently deficient for both chart audits.

Corrective Action Plan(s) (if appropriate): HSA, AHSA, RN Manager and lead medical provider informed of audit results. Re-training and educating medical and nursing providers to take place at next scheduled staff and provider meetings.

HIV (ESSENTIAL)

Facility: **SDC** **Quarter/Fiscal Year:** **1st/2017**
Reviewer: [redacted] **RN**

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with HIV during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with HIV for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Documented HIV+ by laboratory or prior medical record? **(95%)**
2	CD4 and viral load obtained within 30 days of disease identification or recent CD4/viral load results obtained from prior record (recent is within the past 90 days)? **(95%)**
3	Antiretroviral treatment considered and documented? **(100%)**
4	Treatment plan initiated in accordance with chronic care disease guideline within two business days of illness identification. **(95%)**
5	Diagnosis listed in provider SOAP note **(100%)**
6	Diagnosis listed on problem list? **(100%)**
7	Was patient's care plan evaluated by a physician with experience in managing HIV patients within 30 days of HIV identification or admission to IHSC facility (if diagnosis already known)? **(95%)** – this question was re-worded for FY 2016 for clarity
8	Was the patient seen by a medical provider at least every 90 days? **(95%)**
9	Was a PPD or IGRA performed within the last year? Note: if the patient has been positive in the past, an annual CXR is acceptable **(95%)**
10	If applicable, was the CXR completed or verified within 72 hours of health assessment as part of treatment plan? **(95%)**
11	Patient education documented at each encounter? **(95%)**
12	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8	9	10	11	12
1	(b)(6);(b)(7)(C)	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Y	N	Y
2		Y	Y	Y	Y	Y	Y	Y	N/A	Y	Y	Y	N
3		Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Y
4		Y	Y	Y	Y	Y	Y	Y	Y	Y	N/A	N	Y
5		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
6		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
7		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8		Y	Y	Y	Y	Y	Y	Y	N/A	Y	Y	Y	Y
9		Y	Y	Y	Y	Y	Y	Y	N/A	Y	N/A	N	Y
10		Y	N	N	Y	Y	Y	Y	N/A	Y	N/A	N	N
PERCENTAGE		100%	90%	90%	100%	100%	100%	100%	100%	100%	100%	60%	80%

Add additional 10 records if you fall below the threshold.

Record	Alien #	1	2	3	4	5	6	7	8	9	10	11	12
1	(b)(6);(b)(7)(C)	Y	Y	Y	Y	Y	Y	Y	NA	Y	Y	Y	Y
2		Y	Y	Y	Y	Y	Y	Y	NA	Y	Y	Y	Y
3		Y	Y	Y	Y	Y	Y	Y	NA	Y	Y	Y	Y
4		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	No other charts available for review during this period												
PERCENTAGE		100	100	100	100	100	100	100	100	100	100	100	100

Comments: Documentation of CD4 and viral load obtained within 30 days of disease identification or recent CD4/viral load (#2), antiretroviral treatment considered and documented (3#), patient education (#11) and use of translator services (#12) were not in compliance.

Corrective Action Plan(s) (if appropriate): HSA, AHSA, RN Manager and lead medical provider informed of audit results. Re-training and educating medical and nursing providers to take place at next scheduled staff and provider meetings.

TUBERCULOSIS (Detainees being treated for active tuberculosis disease) (ESSENTIAL)

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: LT [redacted] RN

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with tuberculosis (TB) disease during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with TB disease for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	All patients evaluated for TB disease are tested for HIV **(100%)**
2	Pyrazinamide (PZA) and ethambutol (EMB) prescribed for no more than 60 days unless ordered by the advising physician **(100%)**
3	TB patients are seen at least monthly by a medical provider for follow-up visits **(100%)**
4	CXR is obtained 6-8 weeks after initiation of RIPE with comparison to previous CXR(s) **(100%)**
5	Initial cultures are performed with automatic sensitivity testing and culture and sensitivity results (if at least one culture is positive for M. *tb*) are reviewed **(100%)**
6	TB-CM visit note is completed at the time of diagnosis and updated with culture results, drug sensitivity test results (if culture positive), and final case classification within 90 days of diagnosis (**100%)**

Record	Alien #	1	2	3	4	5	6
1	[redacted]	Y	Y	Y	N/A	Y	Y
2		Y	Y	Y	N/A	Y	Y
3		Y	Y	Y	N/A	Y	Y
4		Y	Y	Y	N/A	Y	Y
5		N	Y	Y	N/A	Y	N
6		N	Y	Y	N/A	Y	N
7		N	Y	Y	N/A	Y	Y
8		N	Y	Y	N/A	Y	Y
9		N	Y	Y	N/A	Y	Y
	No other charts available for review during this period						
PERCENTAGE		44%	100%	100%	100%	100%	78%

Comments: Documentation of HIV testing for all patients evaluated for TB disease **(#1)** and TB-CM visit notes (#6) not thoroughly completed or not documented within prescribed window.

Corrective Action Plan(s) (if appropriate): HSA, AHSA and RN Mgr informed of audit results. Intensive training with nursing staff to ensure areas of deficiencies are covered.

SEIZURE DISORDER (ESSENTIAL)

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: LT [redacted] RN

Instructions: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with seizure disorder during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.
To RANDOMLY select, list out the total number of patients diagnosed with seizure disorder for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Documented complete neurological history/assessment at physical examination? **(100%)**
2	Diagnosis listed in provider SOAP note **(100%)**
3	Diagnosis listed on problem list? **(100%)**
4	If applicable, documented serum drug levels obtained and acknowledged every 3 months until stable, then every 6 months, where indicated? **(100%)**
5	Special Needs issued for lower bunk? **(90%)**
6	Treatment plan initiated in accordance with chronic care disease guidelines. **(90%)**
7	Patient education documented at each encounter? **(100%)**
8	Language Access: Use of translator, provider fluency in language or English speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8
1	[redacted]	Y	Y	Y	N	Y	Y	N	N
2		Y	Y	Y	Y	Y	Y	N	N
3		Y	Y	Y	Y	Y	Y	Y	Y
4		Y	Y	Y	NA	Y	Y	Y	N
5		Y	Y	Y	Y	Y	Y	Y	Y
6		Y	Y	Y	Y	N	Y	Y	N
7		Y	Y	Y	Y	Y	Y	Y	N
8		Y	Y	Y	Y	Y	Y	Y	Y
9		Y	N	Y	Y	N	Y	Y	Y
10		Y	Y	Y	NA	Y	Y	Y	Y
	No other charts available for review								
PERCENTAGE		100%	90%	100%	100%	80%	100%	80%	50%

Comments: Lack of diagnosis (#2) in one patient's record, lower bunk special needs form (#5) and patient education (#7) missing from at least patients' records and access to interpretation services (#8) missing in at least five patients' records.

Corrective Action Plan(s) (if appropriate): HSA, AHSA and RN Mgr informed of audit results. Intensive training with medical and nursing staff to ensure importance of education, special needs forms and access to language services provided at each visit.

SICK CALL (URGENT CARE) REVIEW (ESSENTIAL)

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: [redacted], Pharmacy Technician

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records from patients that have been seen for sick call during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of sick call encounters for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Vital signs obtained and documented during assessment? **(100%)**
2	Weight was documented during assessment? **(90%)**
3	A thorough pain assessment (intensity, duration, quality, better/worse, etc.) was documented during assessment? **(100%)**
4	Treatment in accordance with nursing guidelines? **(100%)**
5.	If pediatric patient, were pediatric pain guidelines followed? (**90%)**
6	If appropriate, patient was referred to a higher level of care? (if not appropriate, mark as N/A) **(95%)**
7	Patient education documented at each encounter? (**100%)**
8	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8
1	[redacted]	Y	Y	Y	Y	NA	NA	Y	Y
2		Y	Y	Y	Y	NA	NA	Y	Y
3		Y	Y	Y	Y	NA	NA	Y	Y
4		Y	Y	Y	Y	NA	NA	Y	Y
5		Y	Y	Y	Y	NA	Y	Y	Y
6		Y	Y	Y	Y	NA	NA	Y	Y
7		y	y	y	y	NA	NA	Y	Y
8		Y	Y	Y	Y	NA	NA	Y	Y
9		Y	Y	Y	Y	NA	NA	Y	Y
10		Y	Y	Y	Y	NA	NA	Y	Y
PERCENTAGE		100%	100%	100%	100%	100%	100%	100%	100%

Add additional 10 records if you fall below the threshold.

Comments: All areas above compliance levels.

Corrective Action Plan(s) (if appropriate): No further action needed.

MENTAL ILLNESS WITH PSYCHOTROPIC MEDICATIONS (ESSENTIAL)

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: LCDR [redacted], LCSW, BCD
Instructions: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with mental illness who take psychotropic medications during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with mental illness and prescribed psychotropics during the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	**Measure**
1	Was a BH referral made in a timely manner (within 72 hours of intake or identification)? **(100%)**
2	Diagnosis listed by behavioral health provider in encounter note **(100%)**
3	Diagnosis listed on problem list? **(100%)**
4	If patient takes psychotropic medication, psychotropic medication consent (special consent form) signed for the drug ordered? (**100%)**
5	Clinical assessment, treatment, and follow up plan documented? **(100%)**
6	For patients on antipsychotic medication, was there an AIMS (Abnormal Involuntary Movement Scale) test performed? (**100%)** (physician, MLP, RN can conduct an AIMS test)
7	Was appropriate lab monitoring ordered depending on the psychotropic drug? (**100%)**

Record	Alien #	1	2	3	4	5	6	7
1	(b)(6),(b)(7)(C)	Yes	Yes	Yes	Yes	Yes	N/A	N/A
2		Yes	Yes	Yes	Yes	Yes	N/A	N/A
3		Yes	Yes	Yes	Yes	Yes	N/A	N/A
4		Yes	Yes	Yes	Yes	Yes	N/A	N/A
5		Yes	Yes	Yes	Yes	Yes	N/A	N/A
6		Yes	Yes	Yes	Yes	Yes	N/A	N/A
7		Yes	Yes	Yes	Yes	Yes	N/A	N/A
8		Yes	Yes	Yes	Yes	Yes	N/A	N/A
9		Yes	Yes	Yes	Yes	Yes	N/A	N/A
10		Yes	Yes	Yes	Yes	Yes	N/A	N/A
PERCENTAGE		100%	100%	100%	100%	100%	100%	N/A

Add additional 10 records if you fall below the threshold.

Comments: None.

Corrective Action Plan(s) (if appropriate): No further action needed.

DENTAL CARE (ESSENTIAL)

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: CAPT (b)(6),(b)(7)(C) **DDS**

Instructions: A dentist, dental hygienist, RN, mid-level provider or physician will review appropriate number (see page 1) of records from patients seen by a dentist for treatment within the designated time frame. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

If there are not enough medical records to select the required number of records to review, 100% review will be required.

Sample size: See page 1 of this document.

Item #	Measure
•	Was dental (oral) screening completed and documented within 14 days of arrival to facility (adults)? ***oral screening includes visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist? (100%)
•	Was dental (oral) screening completed and documented within 7 days of arrival to facility (children)? (100%)
3	If applicable, was patient evaluated within 48 hours of referral? (100%)
4	Does clinical note describe findings, diagnosis/assessment, treatment plans? (100%)
5	If applicable, patient scheduled for follow-up treatment as recommended? (100%)
6	Was the oral examination completed by a dentist or scheduled within 12 months of arrival to facility for adults? (100%) oral examination by a dentist includes taking or reviewing the patient's oral history, an oral health and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral cavity.
7	Was the oral examination completed by a dentist or scheduled within 60 business days of arrival to facility for children? (100%)

Record	Alien #	1	2	3	4	5	6	7
1	[redacted]	Y	N/A	N/A	Y	N/A	N/A	N/A
2		Y	N/A	N/A	Y	Y	N/A	N/A
3		Y	N/A	N/A	Y	N/A	N/A	N/A
4		Y	N/A	Y	Y	Y	N/A	N/A
5		Y	N/A	Y	Y	N/A	N/A	N/A
6		Y	N/A	Y	Y	Y	N/A	N/A
7		Y	N/A	Y	Y	N/A	N/A	N/A
8		Y	N/A	Y	Y	N/A	N/A	N/A
9		Y	N/A	Y	Y	Y	Y	N/A
10		Y	N/A	Y	Y	N/A	N/A	N/A
PERCENTAGE		100%	100%	100%	100%	100%	100%	100%

Comments: No deficiencies noted.

Corrective Action Plan(s) (if appropriate): None required.

CONTINUITY OF CARE REVIEW (ESSENTIAL)

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: [redacted] **RN**

Instructions: Health staff (any IHSC staff) will review appropriate number (see page 1) of randomly selected records of patients who went to the Emergency Department during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of applicable medical records for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was a discharge summary/instructions requested or present? **(100%) – (**was a discharge summary/instructions received when the patient returned from the hospital?)
2	Was there a note from the IHSC provider detailing the reason the detainee was sent to the ED? **(100%)**
3	Was a note entered in the medical record upon the detainee's return to the facility listing the ED/hospital's recommended plan of care? **(100%)**
4	Did the provider follow the ED/hospital's recommended plan of care? **(100%)**
5	Upon return from ED, was the patient/parent educated about diagnosis, medications (if applicable) and treatment plan? **(100%)**
6	Is there documentation acknowledging patient/parent understands treatment plan? **(100%)**
7	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7
1	(b)(6),(b)(7)(C)	Yes	Yes	Yes	Yes	Yes	Yes	No
2	[redacted]	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3		Yes	Yes	Yes	Yes	Yes	No	Yes
4		Yes	Yes	Yes	Yes	Yes	No	Yes
5		Yes	Yes	Yes	Yes	Yes	Yes	Yes
6		Yes	Yes	Yes	Yes	Yes	Yes	Yes
7		Yes	Yes	Yes	Yes	No	No	Yes
8		Yes	Yes	Yes	Yes	Yes	Yes	Yes
9		Yes	Yes	Yes	Yes	Yes	Yes	Yes
10		Yes	Yes	Yes	Yes	Yes	Yes	Yes
PERCENTAGE		100%	100%	100%	100%	90%	70%	90%

Add additional 10 records if you fall below the threshold.

Record	Alien #	1	2	3	4	5	6	7
1	(b)(6),(b)(7)(C)	Y	Y	Y	Y	Y	Y	Y
2	[redacted]	Y	Y	Y	Y	Y	Y	Y
3		Y	Y	Y	Y	Y	Y	Y
4		Y	Y	Y	Y	Y	Y	Y
5		Y	N	N	N	N	Y	Y
6		Y	Y	Y	Y	Y	Y	Y
7		Y	Y	Y	Y	Y	Y	Y
8		Y	Y	N	N	N	N	Y
9		Y	Y	Y	Y	Y	Y	Y
10		Y	Y	Y	Y	Y	Y	Y
PERCENTAGE		100%	90%	80%	80%	80%	90%	100%

Comments: Areas deficient during first audit were patient education on diagnosis/meds/tx plan (#5), documentation of patient acknowledging understanding of treatment plan (#6) and use of interpretation services (#7). Area #7 was more compliant during second random audit but areas #5 and #6 remained out of compliance with addition of areas (#2) note from the IHSC provider detailing the reason the detainee was sent to the ED, (#3) note entered in the medical record upon the detainee's return to the facility listing the ED/hospital's recommended plan of care and documentation of the provider following the ED/hospital's recommended plan of care missing from two patients' records.

Corrective Action Plan(s) (if appropriate): Will discuss findings of audit with providers at next provider meeting.

Reasonable Accommodations Self-Assessment

Instructions: Obtain the information from the HSA's Reasonable Accommodation Self-Assessment Tool

	YES or NO
POLICY, PROCEDURES AND TRAINING	
1. Procedures are in place to ensure detainees with disabilities are informed of and have an equal opportunity to request and obtain health services.	Yes – Detainee Handbook, page 3
2. IHSC staff has received initial training on interacting with individuals with disabilities and individuals requiring reasonable accommodations, and annually thereafter.	Yes
3. Written evacuation procedures and emergency communications are in place in the clinic for individuals with disabilities.	Yes
4. Procedures have been established to ensure that accessible features (within the IHSC-staffed facilities) are maintained. (Mark N/A if non-applicable)	Yes
PHYSICAL ACCESSIBILITY	
5. The facility provides reasonable accommodation access for individuals within the Health Unit.	Yes
COMMUNICATION	
6. The IHSC clinic has access to sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities.	Yes

TREATMENT OF DISABILITY

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: LT [redacted] **RN**

Purpose:	To assess care of detainees who need accommodation for their disabilities. An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment (see [redacted] accessed January 20, 2012). An RN, MLP or physician can review.
Source:	Facility logs or tour of facility and interviews with detainees who need accommodation).
Sample:	10 detainees within the population who have a disability that requires special medical treatment. Determine through medical record examination if appropriate treatment and accommodation was given. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.
Item #	**Measure**
1	Is the disability prominently noted in the file, along with any needed accommodations? (100%)
2	Was the detainee assessed for assistance with activities of daily living (ADL)? (100%)
3	Were appropriate special orders entered (e.g., lower bunk, assistive device, meal, etc.)?(100%)
4	Was ADL assistance provided? (100%)

	A #	1	2	3	4
1	[redacted]	Y	Y	N/A	N/A
2		Y	Y	N/A	N/A
3		Y	Y	N/A	N/A
4		Y	Y	Y	Y
5		Y	Y	Y	Y

6	[redacted]	Y	Y	Y	N/A
7		Y	Y	Y	N/A
8		Y	Y	Y	N/A
9		Y	Y	Y	N/A
10		Y	Y	Y	N/A
	Total	100%	100%	100%	100%

Comments: All assessed areas above compliance level.

Corrective Action Plan(s) (if appropriate): No further actions warranted.

MEDICATION REFUSAL

Facility: SDC Quarter/Fiscal Year: 4th/2017
Reviewer: LT [redacted] RN

Purpose:	To assess notification of prescribing clinician of poor adherence to medication orders
Source:	Medication administration records, medical record RN, MLP or physician can review
Sample:	Identify 10 patients from MARs who have missed medication on three consecutive days or four or more doses in a week.
	Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.
Item #	Measure
1 2. 3. 4. 5.	Documented refusal in the medical record (with signature of detainee, witness)? Explanation of risks and benefits documented in the medical record? Documentation that prescribing clinician has been notified if 3 consecutive days or 3 consecutive doses and/or 50% of doses missed within 7 days? Documentation of clinician response in the medical record? If detainee refused to sign refusal form, was it documented on the form?

MEDICATION REFUSAL						
Record	**Alien #**	**Measure 1**	**Measure 2**	**Measure 3**	**Measure 4**	**Measure 5**
1	[redacted]	Y	Y	Y	Y	Y
2		Y	Y	Y	Y	Y
3		Y	Y	Y	Y	Y
4		Y	Y	Y	Y	Y
5		Y	Y	Y	Y	Y
6		Y	Y	Y	Y	Y
7		1	1	1	1	1
8		1	1	1	1	1
9		1	1	1	1	1
10		1	1	1	1	1

0	**PERCENT COMPLIANCE**	**100%**	**100%**	**100%**	**100%**	**100%**

Add additional 10 records if you fall below the threshold.

Comments: No deficiencies noted.

Corrective Action Plan(s) (if appropriate): None.

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

Facility: SDC Quarter/Fiscal Year: 1st/2017
Reviewer: CDF[redacted]PA

Purpose:	To assess timeliness of off-site diagnostic services and specialty care.
Source:	Statistics.
	MLP or physician can review.
Sample:	10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.
	Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.
Item #	**Measure**
1	Documented time urgency on order? **(90%)**
2	Accomplished within 45 days of order or within ordered timeframe, e.g., "return in 90 days"? **(100%)**
3	Documented re-evaluation of patient for deterioration each 30 days in excess of time urgency on order? **(90%)**
4	Clinician acknowledgement and report in medical record within 7 days? **(90%)** 5. Detainee informed of results or reason for delay if not scheduled? (**90%)**

	A #	Clinic	1	2	3	4	5
1	[redacted]	Orthopedics	Yes	Yes	Yes	Yes	N/A
2		ENT	Yes	Yes	Yes	Yes	N/A
3		Prosthesis	Yes	Yes	Yes	Yes	N/A
4		Physical Therapy	Yes	Yes	Yes	Yes	N/A
5		Neurology	Yes	Yes	Yes	Yes	N/A
6		Radiology	Yes	Yes	Yes	Yes	N/A
7		Neurology	Yes	Yes	Yes	Yes	N/A
8		General Surgery	Yes	Yes	Yes	Yes	N/A
9		Physical Therapy	Yes	Yes	Yes	Yes	N/A
10		Prosthesis	Yes	Yes	Yes	Yes	N/A
		Total	100%	100%	100%	100%	N/A

Comments: Compliance was met for all criteria.

Corrective Action Plan(s) (if appropriate): No further actions warranted.

LABORATORY AND DIAGNOSTICS

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: LT [redacted] **RN**

Purpose:	To assess timeliness, continuity, and coordination of care.
Source:	Laboratory log. RN, MLP or physician can review.
Sample:	10 most recent orders for acute labs, not including routine testing for detainees with chronic illness.
	Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.
Item #	**Measure**
Item #	**Measure**
1	Up to date certification for CLIA-waived testing accessible? (100%)
2	Documentation of applicable staff training for performing CLIA-waived tests? (100%)
3	Blood drawn or test done within 1 business day of ordered date? (100%)
4	Results received within 24 hours or as appropriate? (100%)
5	Clinician acknowledgment? (100%)
6	Appropriate clinical response? (100%)
7	Detainee informed of results; if not, reason documented in medical record? (100%)

	A #	1	2	3	4	5	6	7
1	[redacted]	Y	Y	Y	Y	N	N	N
2		Y	Y	Y	Y	N	N	N
3		Y	Y	Y	Y	N	N	N
4		Y	Y	Y	Y	N	N	N
5		Y	Y	Y	Y	N	N	N
6		Y	Y	N	N	Y	N	N
7		Y	Y	Y	Y	Y	Y	Y
8		Y	Y	Y	Y	Y	Y	Y
9		Y	Y	Y	Y	Y	Y	Y
10		N	Y	Y	N	Y	Y	Y
	Total	90 %	100%	90 %	80%	50%	40%	40%

Comments: Deficiencies noted with all areas other than (#2) documentation of staff training for performing CLIA-waived tests. Areas of deficiency included (#1) up-to-date certification for CLIA-waived testing accessible, (#3) blood drawn or test done within 1 business day of date ordered, (#4) results received within 24 hours or as appropriate, (#5) lack of clinician acknowledgment, (#6) appropriate clinical response documented and (#7) documentation of detainee being informed of results.
Corrective Action Plan(s) (if appropriate): HSA, AHSA and RN Mgr informed of audit results. Intensive training with medical and nursing staff to ensure importance of timely documentation and thoroughness at each visit.

CREDENTIALING

Facility: SDC Quarter/Fiscal Year: 1st/2017
Reviewer: (b)(6);(b)(7)(C) Administrative Assistant

Purpose:	To assess compliance with detention standard and prudent institutional risk management practice.
Source:	Up to 10 files for each of all licensed health care professionals.
Sample:	HSA or AHSA will review. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. 10 chosen at random.
Item #	Measure
1	Documentation of primary source validation (e.g., internet) of current license, certification or registrations for all applicable licensed professionals (100%)
2	Validation of DEA for physicians, psychiatrists, and dentists? (100%)
3	Current CPR certificate (100%)
4	Documentation of inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank (NPDB) (100%)

	Title	1	2	3	4
1	RN	Yes	N/A	Yes	Yes
2	Physician	Yes	Yes	Yes	Yes
3	RN	Yes	N/A	Yes	Yes
4	RN	Yes	N/A	Yes	Yes
5	LPN	Yes	N/A	Yes	Yes
6	Pharmacy Tech	Yes	N/A	Yes	Yes
7	Dentist	Yes	Yes	Yes	Yes
8	LPN	Yes	N/A	Yes	Yes
9	FNP	Yes	N/A	Yes	Yes
10	FNP	Yes	N/A	Yes	Yes
		10/10 100 %	2/2 100%	10/10 100%	10/10 100%

Comments: None.
Corrective Action Plan(s) (if appropriate): No further action required.

MORTALITY REVIEW

Facility: SDC Quarter/Fiscal Year: 1st/2017
Reviewer: N/A

Purpose:	To assess the use of mortality review as a quality management activity to prevent adverse system conditions from causing harm in the future.

Source:	Minutes, notes, medical records, other pertinent records. MLP or physician will review.
Sample:	Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. All in-custody deaths, including those in hospital, within the past 2 years.

Item #	Measure
1	Multidisciplinary mortality review (clinical, administrative) within 30 calendar days of death? **(100%)**
2	Follow-up review when autopsy and toxicology reports are available? **(100%)**
3	Assessment as to whether the medical response was appropriate on the day of death or transfer to the hospital? **(100%)**
4	Assessment as to whether earlier intervention was possible and whether that would have changed the outcome? **(100%)**
5	Analysis of ways to improve patient care, independent of the cause of death or RCA completed? **(100%)**
6	For suicides only, was there a psychological autopsy ordered and completed? (**100%)**

7 Was treating staff informed of the clinical mortality review and administrative findings? (**100%**)

	A #	1	2	3	4	5	6	7
1								
2								
3								
4	**No cases met criteria for review in this area**							
5								
6								
7								
8								
9								
10								
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Comments: No comments.

Corrective Action Plan(s) (if appropriate): No further actions warranted

MEDICAL RECORDKEEPING PRACTICES

Facility: SDC **Quarter/Fiscal Year: 1st/2017**
Reviewer: [redacted] **MRT**

Instructions: This worksheet should be filled out following the performance-based reviews. For all answers that are "partial compliance" or "non-compliance," the reviewer should write a comment. For example, if most of the progress notes are legible, but one or two practitioners' notes are barely legible, the appropriate comment would be "Dr. XX.s notes are not legible."

Reviewer can be any health care provider.

Sample: 10 records reviewed on detainees with chronic disease.

		Yes	Partial	No	N/A	Comments
1	Identifying information (100%)	Yes				
2	Current problem list (100%)	Yes				
3	Receiving screen and health assessment forms (100%)	Yes				
4	Progress notes (100%)	Yes				
5	Clinician orders for medication, signed (100%)	Yes				
6	MARs (100%)	Yes				
7	Lab and diagnostic reports (100%)	Yes				
8	Flow sheets (100%)				N/A	
9	Consent, refusal, and release of information forms (100%)	Yes				
10	Results of specialty consultations and referrals (100%)	Yes				
11	Discharge summaries from ED and hospitalizations (100%)	Yes				
12	Special needs treatment plan, where applicable (100%)	Yes				
13	Immunizations records, where applicable (100%)				N/A	-unless received from a previous facility.
14	Date and time of each encounter (100%)	Yes				
15	Integrated medical, dental, and mental health record (100%)	Yes				
16	Timely filing, within 72 hours (100%)	Yes				
17	Consolidated medical record (100%)	Yes				
18	Content organized for easy retrieval (100%)	Yes				
19	EHR password protected, by individual (100%)	Yes				
20	Integrated health information with EHR, where applicable (100%)	Yes				

Comments: SDC utilizes eCW which is an electronic health record that is password protected, consolidated, and time stamps all entries.

Corrective Action Plan(s) (if appropriate): No further actions required.

Department of Homeland Security
Office of Health Affairs
Medical Quality Management Branch

US Immigration and Customs Enforcement (ICE)
Health Services Corps (ISHC)

Continuous Quality Improvement (CQI) and Medical Record Audit Tc

Prepared by:

Capstone
Consulting Group, LLC

The US Department of Homeland Security (DHS) is acknowledged as the sponsor of this work.

ICE HEALTH SERVICE CORPS (IHSC) - CONTINUOUS QUALITY IMPROVEMENT AUDIT TOOL - FY 2016

You will report EVERY quarter on ALL MEASURES that follow. There are 28 measures in total.

- Grievances
- Suicide Watch
- Hunger Strikes
- Medication Errors
    - o Medication Administration Errors
    - o Prescribing/Ordering Errors
    - o Pharmacy Order Errors
    - o Self-administered medications, continuity of medication and medication refusals

Sample Size: For each of these components, you will review 10 charts (unless findings fall below the threshold established [thresholds are listed after each item] – then you must review 10 additional records). NOTE: If there are less than 10 charts, then review 100% of those charts that are applicable.

- Medication Refusal
- Pregnancy Audit
- Medical Housing Unit
- Screening and Health Assessment
- Hypertension
- Diabetes
- Asthma
- HIV
- Tuberculosis

- Seizure Disorder
- Sick Call/Urgent Care
- Mental Illness with Psychotropic Medication
- Dental Care
- Continuity of Care
- Reasonable Accommodations

- Treatment of Disability
- Diagnostic Services and Specialty Care Access
- Laboratory and Diagnostics
- Credentialing
- Mortality Review
- Medical Recordkeeping Practices

THRESHOLDS FOR COMPLIANCE: Each indicator has a percentage of compliance required (written next to it). If you fall below this threshold for compliance, you must submit a corrective action plan for it. The corrective action plan should be written in the section following the data.

GRIEVANCES (IMPORTANT)

IHSC QI Audit Tool

Facility:	**Stewart Detention Center**
Reviewer:	**LCDR** [redacted]
Quarter/Fiscal Year:	**2nd Quarter 2017**

INSTRUCTIONS: Obtain the numbers from the grievance logs.

GRIEVANCES		
	Number	**Percentage of Total Grievances**
1. Total number of grievances received within quarter.	10	
2. Number of grievances addressed* within 5 business days.	8	80%
3. Number of grievances related to access to care.	2	20%
4. Number of grievances related to quality of care.	4	40%
Comments: **None**		
Corrective Action Plan(s) (if appropriate): **None**		

SUICIDE WATCH (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LCDR** [redacted]
Quarter/Fiscal Year:	**2nd Qtr/2017**

INSTRUCTIONS: Enter the total number of detainees in the detention facility in the field "Total Patient Population". Obtain the numbers for 1-8 from intake screenings, suicide watch logs and medical records.

SUICIDE WATCH		Total Patient Population →	1(
	Number	Percentage of Total Number on Suicide Watch	Percentag Patient P
1. Total number of detainees on suicide watch during specified timeframe. (for suicidal ideation, actions)	1		1.(
2. Number of detainees (from number above) on suicide watch during specified time frame who made an actual suicide attempt.	0	0%	
3. Number of incident reports submitted. (required for detainees with suicidal attempt)	1	100%	
4. Number of detainees on suicide watch who were evaluated by behavioral health professionals within 24 hours, unless emergent.(in which case the evaluation should be immediate)	1	100%	
5. Number of detainees on suicide watch (from number above) who were seen previously by IHSC for mental health issues.	1	100%	
6. Number of detainees on suicide watch with daily evaluations done by qualified medical staff.	1	100%	
7. Number of detainees on suicide watch with appropriate documentation. (i.e. 15 minute and 8 hour documentation)	1	100%	
8. Number of detainee on suicide watch that received follow up post/after discharge from suicide watch at interval consistent with the level of acuity. (PBNDS)	1	100%	

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

HUNGER STRIKES (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LCDR** [redacted]
Quarter/Fiscal Year:	**2nd Quarter 2017**

INSTRUCTIONS: Obtain the numbers from hunger strike logs and medical records.

HUNGER STRIKES		
	Number	**Percentage of Total Number on Hunger Strikes**
1. Total number of detainees on hunger strikes within the quarter.	25	
2. Number of detainees requiring medical intervention. (intravenous therapy) ON SITE (not those off-site)	0	0%
3. Number of detainees requiring medical intervention (intravenous therapy) ON SITE(not those off-site) for whom an incident report was submitted.	0	0%
4. Number of detainees on hunger strike with complete documentation. (daily vital signs, daily weights, intake and output)	25	100%
5. Number of detainees on hunger strikes with provider evaluation documented.	25	100%
6. Number of detainees on hunger strike requiring court-ordered force-feeding on site.	0	0%
7. Number of detainees on hunger strike requiring court-ordered force-feeding in hospital.	0	0%
Comments: **N/A**		

Corrective Action Plan(s) (if appropriate):
N/A

MEDICATIONS (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LT** [redacted]
Quarter/Fiscal Year:	**2nd Quarter 2017**

INSTRUCTIONS: Place the number of medication errors (from incident reports) in the column "Number of Errors". Place the number of incident reports submitted in the column next to it. If none, put "0". If not applicable, enter "NA". Do not leave any blank.

MEDICAL ADMINISTRATION ERRORS		
	Number of Errors	**Number of Incident Reports Submitted**
1. Number of wrong medications given.	1	1
2. Number of wrong patients receiving medication.	0	0
3. Number of medications given at wrong time.	0	0
4. Number of medications missed.	4	4
5. Number of medications administered via wrong route.	0	0
6. Number of wrong doses given.	1	1
7. Number of transcription errors.	0	0
8. Number of expired prescriptions given.	0	0
9. Number of blank spaces on medication administration record. (i.e. no documentation of missed medication)	0	0
10. Other **LOST MEDS**	4	4
TOTAL:	**10**	**10**

Comments:

At least one chart revealed wrong med passed, 4 charts revaled meds missed, one chart revealed wrong dose of med passed and 4 incidents of meds being lost by nursing.

Corrective Action Plan(s) (if appropriate):

RN mgr to monitor MARs and provide additional trg on correct procedures to ensure right meds are given at right time. Medication cart has recently been organized and stocked by pharmacist with training completed with nurses on new med cart processes. CAPS currently being implemented per HQ.

PRESCRIBING/ORDERING ERRORS

	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong patients receiving medication	1	1
2. Number of wrong drug - indication	0	0
3. Number of wrong drug - allergy	0	0
4. Number of wrong drug – drug interaction	0	0
5. Number of wrong doses	0	0
6. Number of wrong dosing schedules	0	0
7. Number of orders written incorrectly	0	0
8. Number of medication orders not forwarded to pharmacy	1	1
9. Other	0	0
TOTAL:	**2**	**2**

Comments:

One case of wrong pt receiving medication and one case of medication order not being forwarded to pharmacy

Corrective Action Plan(s) (if appropriate):

Training on using pt identifiers before passing meds provided by RN mgr. Guidance on correct procedure to transmit orders to pharmacy provided by pharmacist.

SELF-ADMINISTRERED MEDICATIONS, CONTINUITY OF MEDICATION, and MEDICATION REFUSAL

	Whole Numbers	Yes/No/NA

1. Estimated number of patients on self-administered medication. (check with pharmacy)	670	
2. If detainee requires continuation of medication, was medication ordered within 24 hours from completion of intake screening? (Review 10 random medical records: Note percent compliance if less than 100%; if 100%, enter "Yes".)		Yes
3. Average lapse time from order to first dose of medication, if greater than 24 hours?	0	
4. Other		

Comments:

Meds provided within 24 hrs however, it is unknown when detainee chooses to take first dose.

Corrective Action Plan(s) (if appropriate):

None

PHARMACY ERRORS

	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong patients.	0	0
2. Number of wrong medications.	0	0
3. Number of wrong doses.	0	0
4. Number of wrong labels.	1	1
5. Number of wrong routes.	0	0
6. Number of MAR errors. (misprinted, medication missing)	0	0
TOTAL:	**1**	**1**

Comments:

one incident of med having wrong label

Corrective Action Plan(s) (if appropriate):
Pharmacist reiterated importance of taking time out to verify contents of container versus label to pharmacy technicians.

MEDICATION REFUSAL

Facility:	Stewart Detention Center
Reviewer:	LT (b)(6);(b)(7)(C)
Quarter/Fiscal Year:	2nd Quarter 2017

PURPOSE: To assess notification of prescribing clinician of poor adherence to medication orders.

Source: Medication administration records, medical record RN, MLP or physician can review.

Sample: Identify 10 patients from MARs who have missed medication on three consecutive days or four or more doses in a week.

Instructions: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Documented refusal in the medical record (with signature of detainee, witness)?
2	Explanation of risks and benefits documented in the medical record?
3	Documentation that prescribing clinician has been notified if 3 consecutive days or 3 consecutive doses and/or 50% of doses missed within 7 days?
4	Documentation of clinician response in the medical record?
5	If detainee refused to sign refusal form, was it documented on the form?

MEDICATION REFUSAL						
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5
1	(b)(6);(b)(7)(C)	1	1	1	1	1
2		1	1	1	1	1
3		1	1	1	1	1
4		1	1	1	1	1
5		1	1	1	1	1
6		1	1	1	1	1
7		1	1	1	1	1
8		1	1	1	1	1

9	[redacted]	1	1	1	1	1
10		1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

PREGNANCY AUDIT (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LCDR [redacted]
Quarter/Fiscal Year:	2nd Quarter 2017

INSTRUCTIONS: A health care provider will review 100% of the charts of the pregnant patients during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable.

Sample size: 100%

Item #	Measure
1	Was an OB-GYN consult ordered and the scheduled appointment time documented within 7 days of identification of condition? (Not necessarily seen within 7 days) (100%)
2	Prenatal vitamins prescribed? (100%)
3	Proper diet ordered? (100%)
4	Patient education documented at each encounter? (100%)
5	Records reviewed by provider after OB appointment? (100%)
6	Appropriate prenatal labs (consideration for HIV, STI, and viral hepatitis) ordered if not obtained from OB-GYN? (100%)

PREGNANCY AUDIT

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6
1	N/A						
2							
3							
4							
5							
6							
7							
8							
9							
10							
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%

Comments:

N/A; all male facility

Corrective Action Plan(s) (if appropriate):

N/A

MEDICAL HOUSING UNIT (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT [redacted]
Quarter/Fiscal Year:	2nd Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of patients who were admitted to the MHU during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable.

To RANDOMLY select, list out the total number of MHU patients for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

IHSC QI Audit Tool

ITEM #	MEASURE
1	Admitting history/current diagnosis or issues documented on the MHU progress note (to be completed by a physician/MLP or appropriate clinician according to scope of practice)? (100%)
2	Appropriate exam documented relevant to the reason for the MHU stay? – e.g. dental, medical, or behavioral health exam? (100%)
3	Provider rounds documented as noted in the treatment plan, if applicable (90%)
4	Treatment plan includes specific instructions for nursing and appropriate precautions or interventions for infectious disease? (90%)
5	Nursing care plan present? (90%)
6	Nursing care follow-up documented? (100%)
7	Nursing progress notes present for each shift? (100%)
8	24 hour chart review indicated with signature, date and time of review? (90%)
9	Discharge from MHU documented, if applicable (100%)
10	Language Access: Use of translator, provider fluency in language, or English-speaking detainee is documented? (100%)

MEDICAL HOUSING UNIT

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10
1	(b)(6);(b)(7)(C)	1	1	1	1	1	1	1	1	1	1
2		1	1	1	1	0	1	0	1	1	1
3		1	1	1	1	0	1	0	0	1	1
4		1	1	1	1	0	1	1	1	1	1
5		1	1	1	1	1	1	0	0	1	1
6		1	1	1	1	1	1	0	0	1	1
7		1	1	1	1	0	1	0	0	1	1
8		1	1	1	1	1	1	0	0	1	1
9		1	1	1	1	1	1	1	1	1	1
10		1	1	1	1	1	1	1	0	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	60%	100%	40%	40%	100%	100%

Comments:

Deficiencies noted with nursing care plan, nursing progress notes for each shift and 24 hr chart reviews were noted.

Corrective Action Plan(s) (if appropriate):

RN mgr to train nursing staff on documentation required for MHU post and ensure they understand the imporatance of thorough, timely documentation.

Add additional 10 records if you fall below the threshold in the table to the right.

Record	Alie
11	(b)(6);(b)(7)(C)
12	
13	
14	
15	
16	
17	
18	
19	
20	
	PERCENT CC

Comments:

All areas other than 24 h

Corrective Action Plan(s

RN mgr to train nursing

IHSC QI Audit Tool

SCREENING AND HEALTH ASSESSMENT (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LT** [redacted]
Quarter/Fiscal Year:	**2nd Quarter 2017**

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review the appropriate number (see page 1) of randomly selected records for patients that have been at the facility for more than two weeks during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

Sample Size: See Instructions in Row 3

Item #	Measure
1	Initial screening completed within 12 hours of admission to facility? (100%)
2	All required areas of the intake template in eCW are completed? (100%)
3	TB screening completed during medical intake if applicable (PPD or CXR)? (100%)
4	PPD read within 48-72 hours? (N/A if CXR performed) (100%)
5	TB clearance properly documented? (100%)
6	Was there timely (NLT 2 working days after identification) follow-up for significant findings of acute and chronic conditions? (100%) (A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health) (100%)
7	Was health assessment completed within 14 days? (100%)
8	Was health assessment completed within 7 days for children? (Family Residential Centers) (100%)
9	Was health assessment completed for patients with chronic illnesses within two working days? (100%)
10	Health assessment (health history and hands-on physical examination) completed by licensed physician/PA/NP/RN (if completed by RN, must have documented training) (100%)
11	If applicable, documentation of transfer summary reviewed within 12 hours? (100%)
12	Patient education documented at each encounter? (100%)
13	Language access: Use of translator, provider fluency in language, or English-speaking patient is documented. (100%)

SCREENING AND HEALTH ASSESSMENT														
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
1	[redacted]	1	1	1	1	1	1	1	NA	1	1	1	1	1
2	[redacted]	1	1	1	NA	1	NA	1	NA	NA	1	1	1	1

3	[redacted]	1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
4		1	1	1	1	1	NA	1	NA	NA	1	1	1	1
5		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
6		1	1	1	1	1	NA	1	NA	NA	1	1	1	1
7		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
8		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
9		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
10		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

HYPERTENSION (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LT** [redacted]
Quarter/Fiscal Year:	**2nd Quarter 2017**

IHSC QI Audit Tool

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with hypertension during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with hypertension for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample Size: See Instructions in Row 3

Item #	Measure
1	Blood pressure reading documented at intake? (100%)
2	Patient seen by medical provider within two business days of illness identification (100%)
3	Patient was referred to MLP or higher, if exam was completed by RN (95%)
4	Patient has treatment plan documented? (95%)
5	Diagnosis listed in provider SOAP note? (100%)
6	Diagnosis listed on problem list? (100%)
7	Baseline labs obtained (CBC, CHEM, lipid profile, UA & EKG) and reviewed within 30 days of illness identification? (100%)
8	Patient education documented at each encounter? (100%)
9	Language access: Use of translator, provider fluency in language or English speaking patient is documented? (100%)

HYPERTENSION

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
1	(b)(6);(b)(7)(C)	1	1	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1	1	1
3		1	1	1	1	1	1	1	1	1
4		1	1	1	1	1	1	1	1	1
5		1	1	1	1	1	1	1	1	1
6		1	1	1	1	1	1	1	1	1
7		1	1	1	1	1	1	1	1	1
8		1	1	1	1	1	1	1	1	1
9		1	1	1	1	1	1	1	1	1
10		1	1	1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

HYPE

Record	Alien #
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	PERCENT COMPLIANCE

Comments:

IHSC QI Audit Tool

Corrective Action Plan(s) (if appropriate):	Corrective Action Plan(s) (if appropr
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

DIABETES (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	RN [redacted]
Quarter/Fiscal Year:	2nd Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with diabetes during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with diabetes for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample Size: See Instructions in Row 3

Item #	Measure
1	Was PE-C completed within two business days if diabetes was identified at time of arrival? (100%)
2	Documented blood sugar on intake (if diabetes identified at intake) or documented reason for not testing e.g. detainee just ate food one hour ago? (90%)
3	Diagnosis listed in provider SOAP note (100%)
4	Diagnosis listed on problem list? (100%)
5	Baseline A1C obtained within 30 days of arrival or within past 3 months? (100%)
6	Baseline measurement of lipids within 30 days? (100%)
7	Documented prescription of aspirin, as clinically indicated? (80%)
8	Degree of control (goal of HgbA1C < 8.0) documented in treatment plan? (90%)
9	Was a strategy to attain diabetes control documented if HgbA1C was above goal? (100%)
10	Patient education documented at each encounter? (100%)
11	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

IHSC QI Audit Tool

DIABETES												
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11
1	[redacted]	1	1	1	1	1	1	1	0	1	1	1
2		1	1	1	1	1	1	1	1	1	1	1
3		1	1	1	1	1	1	0	1	1	1	1
4		1	1	1	1	1	1	1	1	1	1	1
5		1	1	1	1	1	1	1	1	1	1	1
6		1	1	1	1	1	1	1	1	1	1	1
7		1	1	1	1	1	1	1	1	1	1	1
8		1	1	1	1	1	1	1	1	1	1	1
9		1	1	1	1	1	1	1	1	1	1	1
10		1	1	1	1	1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	90%	90%	100%	100%	100%

Comments:
N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

DIABETES
Record
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Comments:

Corrective A

ASTHMA (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT [redacted]
Quarter/Fiscal Year:	2nd Quarter 2017

IHSC QI Audit Tool

INSTRUCTIONS: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with asthma during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with asthma for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? (100%)
2	Peak flow documented during health assessment (100%)
3	Peak flow documented during all chronic care visits? (100%)
4	Diagnosis listed in provider SOAP note (100%)
5	Diagnosis listed on problem list? (100%)
6	Treatment plan initiated in accordance with chronic care disease guidelines. (90%)
7	Patient education documented at each encounter? (100%)
8	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

ASTHMA

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
1	b(6);(b)(7)(C)	1	1	NA	1	1	1	1	1
2		1	1	NA	1	1	1	1	1
3		1	1	NA	1	1	1	1	1
4		1	1	NA	1	1	1	1	1
5		1	1	NA	1	1	1	1	1
6		1	1	NA	1	1	1	1	1
7		1	1	NA	1	1	1	1	1
8		1	1	NA	1	1	1	1	1
9		1	1	NA	1	1	1	1	1
10		1	1	NA	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

ASTHMA - Addit

Record	Alien #	Measure 1
11	N/A	
12		
13		
14		
15		
16		
17		
18		
19		
20		
	PERCENT COMPLIANCE	0%

Comments:

IHSC QI Audit Tool

Corrective Action Plan(s) (if appropriate):	Corrective Action Plan(s) (if appropriate):
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

HIV (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT (b)(6),(b)(7)(C)
Quarter/Fiscal Year:	2nd Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with HIV during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with HIV for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? (100%)
2	Documented HIV+ by laboratory or prior medical record? (95%)
3	CD4 and viral load obtained within 30 days of disease identification or recent CD4/viral load results obtained from prior record (recent is within the past 90 days)? (95%)
4	Antiretroviral treatment considered and documented? (100%)
5	Treatment plan initiated in accordance with chronic care disease guideline within two business days of illness identification. (95%)
6	Diagnosis listed in provider SOAP note (100%)

7 Diagnosis listed on problem list? (100%)
8 Was patient's care plan evaluated by a physician with experience in managing HIV patients within 30 days of HIV identification or admission to IHSC facility (if diagnosis already known)? (95%) This question was re-worded for FY 2016 for clarity
9 Was the patient seen by a medical provider at least every 90 days? (95%)
10 Was a PPD or IGRA performed within the last year? Note: if the patient has been positive in the past, an annual CXR is acceptable (95%)
11 If applicable, was the CXR completed or verified within 72 hours of health assessment as part of treatment plan? (95%)
12 Patient education documented at each encounter? (95%)
13 Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

HIV														
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
1	(b)(6);(b)(7)(C)	1	1	1	1	1	1	1	1	1	NA	1	1	NA
2		1	1	1	1	1	1	1	1	1	1	1	1	NA
3		1	1	1	1	1	1	1	1	1	1	0	1	NA
4		1	1	1	1	1	1	1	1	1	1	1	1	NA
5		1	1	1	1	1	1	1	1	1	1	1	1	NA
6		1	1	1	1	1	1	1	1	1	1	1	1	NA
7		1	1	1	1	1	1	1	1	1	1	1	1	NA
8		1	1	1	1	1	1	1	1	1	NA	1	1	NA
9		1	NA	1	1	1	1	1	NA	1	1	1	1	NA
10		1	1	1	1	1	1	1	NA	1	1	1	1	NA
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

TUBERCULOSIS (Detainees being treated for active tuberculosis disease) (ESSENTIAL)

IHSC QI Audit Tool

Facility:	**Stewart Detention Center**
Reviewer:	**LT** [redacted]
Quarter/Fiscal Year:	**2nd Quarter 2017**

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with tuberculosis (TB) disease during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with TB disease for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	All patients evaluated for TB disease are tested for HIV (100%)
2	Pyrazinamide (PZA) and ethambutol (EMB) prescribed for no more than 60 days unless ordered by the advising physician (100%)
3	TB patients are seen at least monthly by a medical provider for follow-up visits (100%)
4	CXR is obtained 6-8 weeks after initiation of RIPE with comparison to previous CXR(s) (100%)
5	Initial cultures are performed with automatic sensitivity testing and culture and sensitivity results (if at least one culture is positive for M. tb) are reviewed (100%)
6	TB-CM visit note is completed at the time of diagnosis and updated with culture results, drug sensitivity test results (if culture positive), and final case classification within 90 days of diagnosis (100%)

TUBERCULOSIS (ESSENTIAL)							
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

TUBERCULOSIS (ESSENTIAL) - Additional Records If Firs				
Record	Alien #	Measure 1	Measure 2	Measure 3
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

PERCENT COMPLIANCE						
Comments: **No pt diagnosed withTB during review period.**						
Corrective Action Plan(s) (if appropriate): N/A						

Add additional 10 records if you fall below the threshold in the table to the right.

PERCENT COMPLIANCE			
Comments:			
Corrective Action Plan(s) (if appropriate):			

SEIZURE DISORDER (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LT** [redacted]
Quarter/Fiscal Year:	**2nd Quarter 2017**

IHSC QI Audit Tool

INSTRUCTIONS: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with seizure disorder during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with seizure disorder for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? (100%)
2	2 Documented complete neurological history/assessment at physical examination? (100%)
3	Patient was referred to MLP or higher, if exam was completed by RN (95%)
4	Patient has treatment plan documented? (95%)
5	Diagnosis listed in provider SOAP note? (100%)
6	Diagnosis listed on problem list? (100%)
7	Baseline labs obtained (CBC, CHEM, lipid profile, UA & EKG) and reviewed within 30 days of illness identification? (100%)
8	Patient education documented at each encounter? (100%)
9	Language access: Use of translator, provider fluency in language or English speaking patient is documented? (100%)

SEIZURE DISORDER

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
1	[redacted]	1	1	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1	1	1
3		1	1	1	NA	1	1	1	1	1
4		1	1	1	1	1	1	1	1	1
5		1	1	1	NA	1	1	1	1	1
6		1	1	1	1	1	1	1	1	1
7		1	1	1	1	1	1	1	1	1
8		1	1	1	1	1	1	1	1	1
9		1	1	1	NA	1	1	1	1	1
10		NA	1	1	NA	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

SEIZUR

Record	Alien #
11	N/A
12	
13	
14	
15	
16	
17	
18	
19	
20	
	PERCENT COMPLIANCE

Comments:

IHSC QI Audit Tool

Corrective Action Plan(s) (if appropriate):	Corrective Action Plan(s) (if appropr
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

SICK CALL (URGENT CARE) (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT (b)(6);(b)(7)(C)
Quarter/Fiscal Year:	2nd Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records from patients that have been seen for sick call during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of sick call encounters for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	Vital signs obtained and documented during assessment? (100%)
2	Weight was documented during assessment? (90%)
3	A thorough pain assessment (intensity, duration, quality, better/worse, etc.) was documented during assessment? (100%)
4	Treatment in accordance with nursing guidelines? (100%)
5	If pediatric patient, were pediatric pain guidelines followed? (90%)
6	If appropriate, patient was referred to a higher level of care? (if not appropriate, Enter as N/A) (95%)
7	Patient education documented at each encounter? (100%)
8	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

SICK CALL (URGENT CARE)									
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
1	(b)(6);(b)(7)(C)	1	1	1	1	NA	NA	1	1

SICK CALL (URGENT CARE		
Record	Alien #	Measure 1
11	N/A	

2	[redacted]	1	1	1	1	NA	NA	1	1
3		1	1	1	1	NA	NA	1	1
4		1	1	1	1	NA	NA	1	1
5		1	1	1	1	NA	1	1	1
6		1	1	1	1	NA	1	1	1
7		1	1	1	1	NA	NA	1	1
8		1	1	1	1	NA	NA	1	1
9		1	1	1	1	NA	NA	1	1
10		1	1	1	1	NA	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%

12		
13		
14		
15		
16		
17		
18		
19		
20		
	PERCENT COMPLIANCE	0%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Comments:

Corrective Action Plan(s) (if appropriate):

Add additional 10 records if you fall below the threshold in the table to the right.

MENTAL ILLNESS WITH PSYCHOTROPIC MEDICATIONS (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LCDR** [redacted]
Quarter/Fiscal Year:	**2nd Quarter 2017**

IHSC QI Audit Tool

INSTRUCTIONS: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with mental illness who take psychotropic medications during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with mental illness and prescribed psychotropics during the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was a BH referral made in a timely manner (within 72 hours of intake or identification)? (100%)
2	Diagnosis listed by behavioral health provider in encounter note (100%)
3	Diagnosis listed on problem list? (100%)
4	If patient takes psychotropic medication, psychotropic medication consent (special consent form) signed for the drug ordered? (100%)
5	Clinical assessment, treatment, and follow up plan documented? (100%)
6	For patients on antipsychotic medication, was there an AIMS (Abnormal Involuntary Movement Scale) test performed? (100%) (physician, MLP, RN can conduct an AIMS test)
7	Was appropriate lab monitoring ordered depending on the psychotropic drug? (100%)

MENTAL ILLNESS WITH PSYCHOTROPIC MEDICATIONS								
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	[redacted]	1	1	1	1	1	NA	1
2		1	1	1	1	1	NA	1
3		1	1	1	1	1	NA	1
4		1	1	1	1	1	1	1
5		1	1	1	1	1	NA	1
6		1	1	1	1	1	NA	1
7		1	1	1	1	1	NA	1
8		1	1	1	1	1	1	1
9		1	1	1	1	1	NA	1
10		1	1	1	1	1	NA	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	

MENTAL ILLNESS WITH PSYCHOTROPIC MED Below T			
Record	Alien #	Measure 1	Measure 2
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
	PERCENT COMPLIANCE	0%	0%

Comments:	Comments:
N/A	
Corrective Action Plan(s) (if appropriate):	**Corrective Action Plan(s) (if appropriate):**
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

DENTAL CARE (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	CAPT [redacted]
Quarter/Fiscal Year:	2nd Quarter 2017

IHSC QI Audit Tool

INSTRUCTIONS: A dentist, dental hygienist, RN, mid-level provider or physician will review appropriate number (see page 1) of records from patients seen by a dentist for treatment within the designated time frame.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

If there are not enough medical records to select the required number of records to review, 100% review will be required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was dental (oral) screening completed and documented within 14 days of arrival to facility (adults)? ***oral screening includes visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist? (100%)
2	Was dental (oral) screening completed and documented within 7 days of arrival to facility (children)? (100%)
3	If applicable, was patient evaluated within 48 hours of referral? (100%)
4	Does clinical note describe findings, diagnosis/assessment, treatment plans? (100%)
5	If applicable, patient scheduled for follow-up treatment as recommended? (100%)
6	Was the oral examination completed by a dentist or scheduled within 12 months of arrival to facility for adults? (100%) - oral examination by a dentist includes taking or reviewing the patient's oral history, an oral health and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral cavity.
7	Was the oral examination completed by a dentist or scheduled within 60 business days of arrival to facility for children? (100%)

DENTAL CARE								
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	[redacted]	1	NA	1	1	NA	1	NA
2		1	NA	1	1	NA	1	NA
3		1	NA	NA	1	NA	1	NA
4		1	NA	NA	1	1	1	NA
5		1	NA	NA	1	1	1	NA
6		1	NA	NA	1	1	1	NA
7		1	NA	NA	1	1	1	NA
8		1	NA	NA	1	1	1	NA
9		1	NA	NA	1	1	1	NA
10		1	NA	NA	1	1	1	NA
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%

DENTAL CARE - Additional Recor			
Record	Alien #	Measure 1	Measure 2
11	N/A		
12			
13			
14			
15			
16			
17			
18			
19			
20			
	PERCENT COMPLIANCE	0%	0%

Comments:	Comments:
N/A	
Corrective Action Plan(s) (if appropriate):	**Corrective Action Plan(s) (if appropriate):**
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

CONTINUITY OF CARE REVIEW (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	RN [redacted]
Quarter/Fiscal Year:	2nd Quarter 2017

INSTRUCTIONS: Health staff (any IHSC staff) will review appropriate number (see page 1) of randomly selected records of patients who went to the Emergency Department during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of applicable medical records for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	Was a discharge summary/instructions requested or present? (100%) – (was a discharge summary/instructions received when the patient returned from the hospital?)
2	Was there a note from the IHSC provider detailing the reason the detainee was sent to the ED? (100%)
3	Was a note entered in the medical record upon the detainee's return to the facility listing the ED/hospital's recommended plan of care? (100%)
4	Did the provider follow the ED/hospital's recommended plan of care? (100%)
5	Upon return from ED, was the patient/parent educated about diagnosis, medications (if applicable) and treatment plan? (100%)
6	Is there documentation acknowledging patient/parent understands treatment plan? (100%)
7	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

CONTINUITY OF CARE								
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	(b)(6),(b)(7)(C)	1	1	1	NA	NA	1	1
2		1	1	1	1	1	1	1
3		1	1	1	1	1	1	1
4		1	1	1	1	1	1	1
5		1	1	1	1	1	1	1
6		1	1	1	1	1	1	1
7		1	1	1	1	1	1	1
8		1	1	1	1	1	1	1
9		1	1	1	1	1	1	1
10		1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

CONTINUITY OF CARE - Additional R			
Record	Alien #	Measure 1	Measure 2
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
	PERCENT COMPLIANCE	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

REASONABLE ACCOMMODATIONS SELF-ASSESSMENT

Facility:	Stewart Detention Center
Reviewer:	LCDR (b)(6),(b)(7)(C)
Quarter/Fiscal Year:	2nd Quarter 2017

INSTRUCTIONS: Obtain the information from the HSA's Reasonable Accommodation Self-Assessment Tool.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

REASONABLE ACCOMMODATIONS SELF-ASSESSMENT	
POLICY, PROCEDURES, and TRAINING	**YES (1) or NO (0)**
1. Procedures are in place to ensure detainees with disabilities are informed of and have an equal opportunity to request and obtain health services.	1
2. IHSC staff has received initial training on interacting with individuals with disabilities and individuals requiring reasonable accommodations, and annually thereafter.	1
3. Written evacuation procedures and emergency communications are in place in the clinic for individuals with disabilities.	1
4. Procedures have been established to ensure that accessible features (within the IHSC-staffed facilities) are maintained. (Enter N/A if non-applicable)	1
PHYSICAL ACCESSIBILITY	
5. The facility provides reasonable accommodation access for individuals within the Health Unit.	1
COMMUNICATION	
6. The IHSC clinic has access to sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities.	1
PERCENT COMPLIANCE:	**100%**
Comments: N/A	
Corrective Action Plan(s) (if appropriate): N/A	

TREATMENT OF DISABILITIES

Facility:	**Stewart Detention Center**
Reviewer:	**LT** b(6)(b)(C)
Quarter/Fiscal Year:	**2nd Quarter 2017**

IHSC QI Audit Tool

PURPOSE: To assess care of detainees who need accommodation for their disabilities. An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. (see http://www.ada.gov/q%26aeng02.htm , accessed January 20, 2012).

An RN, MLP or physician can review.

SOURCE: Facility logs or tour of facility and interviews with detainees who need accommodation.

Sample: 10 detainees within the population who have a disability that requires special medical treatment. Determine through medical record examination if appropriate treatment and accommodation was given.

Instructions: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations? (100%)
2	Was the detainee assessed to determine if the disability limits one or more major life activity (as defined by ADA: basic activities that the average person in the general population can perform with little or no difficulty, such as (but not limited to) caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, concentrating, thinking, interacting with others and working. A major life activity can also include the operation of a major bodily function)?
3	Were appropriate special orders entered (e.g., lower bunk, assistive device, meal, etc.)? (100%)
4	Was ADL assistance provided? (100%)

TREATMENT OF DISABILITIES

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4
1	[redacted]	1	1	1	1
2		1	1	1	NA
3		1	1	1	NA
4		1	1	1	NA
5		1	1	1	NA
6		1	1	1	NA
7		1	1	1	NA
8		1	1	1	NA
9		1	1	1	NA
10		1	1	1	NA
	PERCENT COMPLIANCE	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):
N/A

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

Facility:	Stewart Detention Center
Reviewer:	LT [redacted]
Quarter/Fiscal Year:	2nd Quarter 2017

PURPOSE: To assess timeliness of off-site diagnostic services and specialty care.

SOURCE: Statistics

MLP or physician can review.

SAMPLE: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

INSTRUCTIONS: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Documented time urgency on order? (90%)
2	Accomplished within 45 days of order or within ordered timeframe, e.g., “return in 90 days”? (100%)
3	Documented re-evaluation of patient for deterioration each 30 days in excess of time urgency on order? (90%)
4	Clinician acknowledgement and report in medical record within 7 days? (90%)
5	Detainee informed of results or reason for delay if not scheduled? (90%)

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

DIAGNOSTIC SERVICES AND SPECIALTY CAR
Below T

IHSC QI Audit Tool

Record	Alien #	Clinic	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5
1	(b)(6);(b)(7)(C)	urology	NA	1	1	1	1
2		ER	NA	1	1	1	1
3		podiatry	NA	1	1	1	1
4		pulmonology	NA	1	1	1	1
5		internal medicine	NA	1	1	1	1
6		ENT	NA	1	1	1	1
7		urology	NA	1	1	1	1
8		cardiology	1	1	1	1	1
9		cardiology	1	1	1	1	1
10		ENT	NA	1	1	1	1
		PERCENT COMPLIANCE	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

Record	Alien #	Clinic
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
		PERCENT COMPLIANCE

Comments:

Corrective Action Plan(s) (if appropriate):

LABORATORY AND DIAGNOSTICS

Facility:	**Stewart Detention Center**
Reviewer:	**RN** (b)(6);(b)(7)(C)
Quarter/Fiscal Year:	**2nd Quarter 2017**

IHSC QI Audit Tool

PURPOSE: To assess timeliness, continuity, and coordination of care.

Source: Laboratory log.

RN, MLP or physician can review.

Sample: 10 most recent orders for acute labs, not including routine testing for detainees with chronic illness.

Instructions: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Up to date certification for CLIA-waived testing accessible? (100%)
2	Documentation of applicable staff training for performing CLIA-waived tests? (100%)
3	Blood drawn or test done within 1 business day of ordered date? (100%)
4	Results received within 24 hours or as appropriate? (100%)
5	Clinician acknowledgment? (100%)
6	Appropriate clinical response? (100%)
7	Detainee informed of results; if not, reason documented in medical record? (100%)

LABORATORY AND DIAGNOSTICS

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	(b)(6);(b)(7)(C)	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1
3		1	1	1	1	1	1	1
4		1	1	1	1	1	1	1
5		1	1	1	1	1	1	1
6		1	1	1	1	1	1	1
7		1	1	1	1	1	1	1
8		1	1	1	1	1	1	1
9		1	1	1	1	1	1	1
10		1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

LABORATORY AND DIAGNOSTICS - Additional

Record	Alien #	Measure 1	Measure 2
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
	PERCENT COMPLIANCE	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):	Corrective Action Plan(s) (if appropriate):
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

CREDENTIALING

Facility:	Stewart Detention Center
Reviewer:	CAPT (b)(6),(b)(7)(C)
Quarter/Fiscal Year:	2nd Quarter 2017

Purpose: To assess credentials of all health care professionals, ensuring they are legally qualified to provide services consistent with licensure, certification, and registration requirements of the practicing jurisdiction.

Source: Up to 10 fields for each of all licensed health care professionals.

HSA or AHSA will review

Instructions: Enter as "1" for yes, "0" for no, and "NA1" for not applicable. Do not leave any area blank.

Sample: 10 chosen at random

Item #	Measure
1	Documentation of primary source validation (e.g., internet) of current license, certification or registrations for all applicable licensed professionals (100%)
2	Validation of DEA for physicians, psychiatrists, and dentists? (100%)
3	Current CPR certificate (100%)
4	Documentation of inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank (NPDB) (100%)

CREDENTIALING					
Record	Employee	Measure 1	Measure 2	Measure 3	Measure 4
1	RN	1	0	1	1
2	RN	1	0	1	1

3	NP	1	0	1	1
4	RN	1	0	1	1
5	LPN	1	0	1	1
6	RN	1	0	1	1
7	PA	1	0	1	1
8	LPN	1	0	1	1
9	RN	1	0	1	1
10	LPN	1	0	1	1
	PERCENT COMPLIANCE	100%	0%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

MORTALITY REVIEW

Facility:	Stewart Detention Center
Reviewer:	LCDR [redacted]
Quarter/Fiscal Year:	2nd Quarter 2017

IHSC QI Audit Tool

INSTRUCTIONS: To determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

SOURCE: Minutes, notes, medical records, emergency response, and other pertinent documents.

MLP or physician will review.

INSTRUCTIONS: Enter as "1" for yes, "0" for no, and "NA" for not applicable. Do not leave any area blank.

SAMPLE: All in-custody deaths, including those in hospital, within the past quarter. If applicable, most of the information can be requested through the HAS or designee.

ITEM #	MEASURE
1	Multidisciplinary mortality review (clinical, administrative) within 30 calendar days of death (this review is completed by HQ. Request information from HSA)? (100%)
2	Follow-up review when autopsy and toxicology reports are available? (100%)
3	Assessment as to whether the medical response was appropriate on the day of death or transfer to the hospital? (100%)
4	Assessment as to whether earlier intervention was possible and whether that would have changed the outcome? (100%)
5	Analysis of ways to improve patient care, independent of the cause of death or RCA completed? (100%)
6	For suicides only, was there a psychological autopsy ordered/completed? (100%)
7	Was the involved staff informed of the clinical mortality review and administrative findings? (100%)
8	Was treating staff informed of the clinical mortality review and administrative findings? (100%)

DEFINITION:

Clinical mortality review is an assessment of clinical care provided and the circumstances leading up to the death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved. (This information is collected by the HSA, IHSC Compliance Investigations and Risk Management)

Administrative morality review is an assessment of correctional and emergency response actions surrounding the detainee's death. Its purpose is to identify areas where facility operations, policies and procedures can be improved. (This information is collected by the HSA, IHSC Compliance Investigations and Risk Management)

MORTALITY REVIEW									
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
1	N/A								
2									
3									
4									
5									
6									

7									
8									
9									
10									
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%	0%

Comments:

No mortalities during this time period

Corrective Action Plan(s) (if appropriate):

None needed

MEDICAL RECORDKEEPING PRACTICES

Facility:	Stewart Detention Center
Reviewer:	(b)(6);(b)(7)(C)
Quarter/Fiscal Year:	2nd Quarter 2017

INSTRUCTIONS:

- This worksheet should be filled out following the performance-based reviews.
- Put a "1" in the appropriate column (Yes, Partial, No, or N/A) for each measure.
  - o For example, if all 10 records comply with "identifying information", then a 1 should be placed in the YES column.
  - o If only some of the records comply, a 1 should be placed in the PARTIAL column.
  - o If none comply, a 1 should be placed in the NO column.
  - o Only put a 1 in ONE of the 4 columns (Yes/Partial/No/NA) for each criteria.
- For all answers that are “partial compliance” or “non-compliance,” the reviewer should write a comment.
  - o For example, if most of the progress notes are legible, but one or two practitioners’ notes are barely legible, the appropriate comment would be “Dr. XX.s notes are not legible.”
- Reviewer can be any health care provider.

SAMPLE: 10 Records reviewed on detainees with chronic disease.

MEDICAL RECORDKEEPING PRACTICES						
		YES	PARTIAL	NO	N/A	COMMENTS
1	Identifying information (100%)	1				
2	Current problem list (100%)	1				
3	Receiving screen and health assessment forms (100%)	1				
4	Progress notes (100%)	1				
5	Clinician orders for medication, signed (100%)	1				
6	MARs (100%)	1				
7	Lab and diagnostic reports (100%)	1				
8	Flow sheets (100%)	1				
9	Consent, refusal, and release of information forms (100%)	1				
10	Results of specialty consultations and referrals (100%)	1				
11	Discharge summaries from ED and hospitalizations (100%)	1				
12	Special needs treatment plan, where applicable (100%)	1				
13	Immunizations records, where applicable (100%)	1				
14	Date and time of each encounter (100%)	1				
15	Integrated medical, dental, and mental health record (100%)	1				
16	Timely filing, within 72 hours (100%)	1				
17	Consolidated medical record (100%)	1				
18	Content organized for easy retrieval (100%)	1				
19	EHR password protected, by individual (100%)	1				
20	Integrated health information with EHR, where applicable (100%)	1				
	PERCENT COMPLIANCE	100%	0%	0%	0%	

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Evaluate an additional 10 records if you fall below the threshold in parentheses. Follow the instructions above the table to include the results for the additional 10 records in the appropriate columns of the table.

)0
e of Total opulation
)%

MEDICAL HOUSING UNIT - Additional Records If First 10 Are Below Threshold										
n #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10
[redacted]	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	0	1	1	0	1	1
	1	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	0	0	1	1
OMPLIANCE	100%	100%	100%	100%	90%	100%	90%	40%	100%	100%

ır chart reviews came into compliance.

) (if appropriate):

staff on documentation required for MHU post and ensure they understand the imporatance of thorough, timely documentation.

SCREENING AND HEALTH ASSESSMENT - Additional Records If First 10 Are Below Threshold														
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
11														
12														

13														
14														
15														
16														
17														
18														
19														
20														
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

RTENSION - Additional Records If First 10 Are Below Threshold								
Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
0%	0%	0%	0%	0%	0%	0%	0%	0%

riate):

- Additional Records If First 10 Are Below Threshold											
Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11
PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

ction Plan(s) (if appropriate):

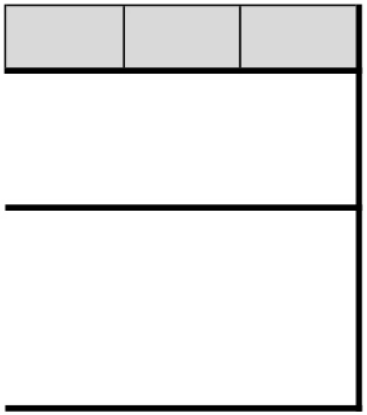
ional Records If First 10 Are Below Threshold						
Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
0%	0%	0%	0%	0%	0%	0%

HIV - Additional Records If First 10 Are Below Threshold														
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
11	(b)(6);(b)(7)(C)	1	1	1	1	1	1	1	NA	1	1	1	1	NA
12		1	1	1	1	1	1	1	1	1	1	1	1	NA
13		1	1	1	1	1	1	1	NA	1	1	1	1	NA
14		1	1	1	1	1	1	1	NA	1	1	1	1	NA
15		1	1	1	1	1	1	1	NA	1	1	1	1	NA
16		1	1	1	1	1	1	1	NA	1	1	1	1	NA
17		1	1	1	1	1	1	1	NA	1	1	1	1	NA
18		1	1	1	1	1	1	1	1	1	NA	1	1	NA
19		1	1	1	1	1	1	1	1	1	1	1	1	NA
20		1	1	1	1	1	1	1	1	1	1	1	1	NA
	PERCENT COMPLIANCE	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%

Comments:

Corrective Action Plan(s) (if appropriate):

t 10 Are Below Threshold		
Measure 4	Measure 5	Measure 6



E DISORDER - Additional Records If First 10 Are Below Threshold

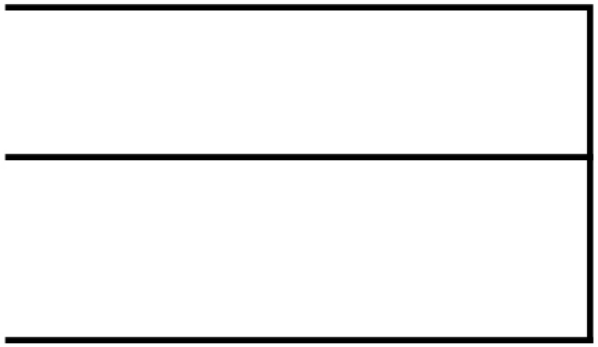
Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
0%	0%	0%	0%	0%	0%	0%	0%	0%

riate):

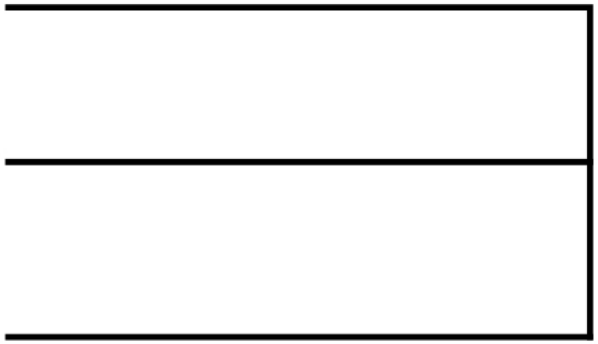
E) - Additional Records If First 10 Are Below Threshold						
Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8

0%	0%	0%	0%	0%	0%	0%

ICATIONS - Additional Records If First 10 Are Threshold				
Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
0%	0%	0%	0%	0%



ds If First 10 Are Below Threshold				
Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
0%	0%	0%	0%	0%



ecords If First 10 Are Below Threshold				
Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
0%	0%	0%	0%	0%

E ACCESS - Additional Records If First 10 Are
hreshold

Measure 1	Measure 2	Measure 3	Measure 4	Measure 5
0%	0%	0%	0%	0%

Records If First 10 Are Below Threshold				
Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
0%	0%	0%	0%	0%

Workbook Protection

(b)(7)(E)

Password for protected sheets: (b)(7)(E)

Department of Homeland Security
Office of Health Affairs
Medical Quality Management Branch

US Immigration and Customs Enforcement (ICE)
Health Services Corps (ISHC)

Continuous Quality Improvement (CQI) and Medical Record Audit Tc

Prepared by:

Capstone
Consulting Group, LLC

The US Department of Homeland Security (DHS) is acknowledged as the sponsor of this work.

ICE HEALTH SERVICE CORPS (IHSC) - CONTINUOUS QUALITY IMPROVEMENT AUDIT TOOL - FY 2017

You will report EVERY quarter on ALL MEASURES that follow. There are 28 measures in total.

- Grievances
- Suicide Watch
- Hunger Strikes
- Medication Errors
    - o Medication Administration Errors
    - o Prescribing/Ordering Errors
    - o Pharmacy Order Errors
    - o Self-administered medications, continuity of medication and medication refusals

Sample Size: For each of these components, you will review 10 charts (unless findings fall below the threshold established [thresholds are listed after each item] – then you must review 10 additional records). NOTE: If there are less than 10 charts, then review 100% of those charts that are applicable.

- Medication Refusal
- Pregnancy Audit
- Medical Housing Unit
- Screening and Health Assessment
- Hypertension
- Diabetes
- Asthma
- HIV
- Tuberculosis

- Seizure Disorder
- Sick Call/Urgent Care
- Mental Illness with Psychotropic Medication
- Dental Care
- Continuity of Care
- Reasonable Accommodations

- Treatment of Disability
- Diagnostic Services and Specialty Care Access
- Laboratory and Diagnostics
- Credentialing
- Mortality Review
- Medical Recordkeeping Practices

THRESHOLDS FOR COMPLIANCE: Each indicator has a percentage of compliance required (written next to it). If you fall below this threshold for compliance, you must submit a corrective action plan for it. The corrective action plan should be written in the section following the data.

GRIEVANCES (IMPORTANT)

IHSC QI Audit Tool

Facility:	**Stewart Detention Center**
Reviewer:	**LCDR** [redacted]
Quarter/Fiscal Year:	**3rd Quarter 2017**

INSTRUCTIONS: Obtain the numbers from the grievance logs.

GRIEVANCES		
	Number	**Percentage of Total Grievances**
1. Total number of grievances received within quarter.	18	
2. Number of grievances addressed* within 5 business days.	18	100%
3. Number of grievances related to access to care.	14	78%
4. Number of grievances related to quality of care.	4	22%
Comments: None		
Corrective Action Plan(s) (if appropriate): None		

SUICIDE WATCH (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LCDR** [redacted]
Quarter/Fiscal Year:	**3rd Qtr/2017**

INSTRUCTIONS: Enter the total number of detainees in the detention facility in the field "Total Patient Population". Obtain the numbers for 1-8 from intake screenings, suicide watch logs and medical records.

IHSC QI Audit Tool

SUICIDE WATCH		Total Patient Population →	19
	Number	Percentage of Total Number on Suicide Watch	Percentag Patient P
1. Total number of detainees on suicide watch during specified timeframe. (for suicidal ideation, actions)	3		0.2
2. Number of detainees (from number above) on suicide watch during specified time frame who made an actual suicide attempt.	0	0%	
3. Number of incident reports submitted. (required for detainees with suicidal attempt)	0	0%	
4. Number of detainees on suicide watch who were evaluated by behavioral health professionals within 24 hours, unless emergent.(in which case the evaluation should be immediate)	3	100%	
5. Number of detainees on suicide watch (from number above) who were seen previously by IHSC for mental health issues.	1	33%	
6. Number of detainees on suicide watch with daily evaluations done by qualified medical staff.	3	100%	
7. Number of detainees on suicide watch with appropriate documentation. (i.e. 15 minute and 8 hour documentation)	1	33%	
8. Number of detainee on suicide watch that received follow up post/after discharge from suicide watch at interval consistent with the level of acuity. (PBNDS)	3	100%	

Comments: Two of the three detainees were missing observation logs for period of time they were under suicide watch.

Corrective Action Plan(s) (if appropriate): BHPs will ensure that the missing observation logs are located, completed in their entirety and forwarded to MRTs for scanning into the detainees' EMR. All staff will be reminded, educated and trained on importance of ensuring that observation logs are thoroughly completed and accounted for daily.

IHSC QI Audit Tool

HUNGER STRIKES (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LCDR** [redacted]
Quarter/Fiscal Year:	**3rd Quarter 2017**

INSTRUCTIONS: Obtain the numbers from hunger strike logs and medical records.

HUNGER STRIKES		
	Number	**Percentage of Total Number on Hunger Strikes**
1. Total number of detainees on hunger strikes within the quarter.	18	
2. Number of detainees requiring medical intervention. (intravenous therapy) ON SITE (not those off-site)	0	0%
3. Number of detainees requiring medical intervention (intravenous therapy) ON SITE(not those off-site) for whom an incident report was submitted.	0	0%
4. Number of detainees on hunger strike with complete documentation. (daily vital signs, daily weights, intake and output)	4	21%
5. Number of detainees on hunger strikes with provider evaluation documented.	18	100%
6. Number of detainees on hunger strike requiring court-ordered force-feeding on site.	1	5%
7. Number of detainees on hunger strike requiring court-ordered force-feeding in hospital.	0	0%
Comments: Nursing staff is not using the MHU: Hungerstrike Monitoring Form or MHU: Intakes/Outputs form to record intakes/outputs or significant findings from labs. Four records revealed detainees refusing nursing assessments. Every detainee on hunger strike had regular provider contact throughout their time on hunger strike		
Corrective Action Plan(s) (if appropriate): Nursing staff to be educated, trained and instructed on proper use of templates when documenting on hungerstrike detainees. Medical staff will continue to conduct their evaluationsand make eCW entries for all MHU pts in a timely manner .		

IHSC QI Audit Tool

MEDICATIONS (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LT** [redacted]
Quarter/Fiscal Year:	**3rd Quarter 2017**

INSTRUCTIONS: Place the number of medication errors (from incident reports) in the column "Number of Errors". Place the number of incident reports submitted in the column next to it. If none, put "0". If not applicable, enter "NA". Do not leave any blank.

MEDICAL ADMINISTRATION ERRORS		
	Number of Errors	**Number of Incident Reports Submitted**
1. Number of wrong medications given.	1	0
2. Number of wrong patients receiving medication.	0	0
3. Number of medications given at wrong time.	2	2
4. Number of medications missed.	0	0
5. Number of medications administered via wrong route.	0	0
6. Number of wrong doses given.	4	1
7. Number of transcription errors.	0	0
8. Number of expired prescriptions given.	0	0
9. Number of blank spaces on medication administration record. (i.e. no documentation of missed medication)	0	0
10. Other **LOST MEDS**	6	3
TOTAL:	**13**	**6**

Comments:

At least one chart revealed wrong med passed, 2 charts revealed meds given at the wrong time, 4 charts revealed wrong doses given, missed, and 6 incidents of meds being lost by nursing.

Corrective Action Plan(s) (if appropriate):

RN Mgr/CC to review MARs daily to ensure MARs are completely filled out and provide additional trg on correct procedures to ensure right meds are given at right time.

PRESCRIBING/ORDERING ERRORS		
	Number of Errors	**Number of Incident Reports Submitted**
1. Number of wrong patients receiving medication	0	0
2. Number of wrong drug - indication	0	0
3. Number of wrong drug - allergy	0	0
4. Number of wrong drug – drug interaction	0	0
5. Number of wrong doses	0	0
6. Number of wrong dosing schedules	0	0
7. Number of orders written incorrectly	0	0
8. Number of medication orders not forwarded to pharmacy	0	0
9. Other	0	0
TOTAL:	**0**	**0**

Comments:

NA

Corrective Action Plan(s) (if appropriate):

NA

SELF-ADMINISTRERED MEDICATIONS, CONTINUITY OF MEDICATION, and MEDICATION REFUSAL		
	Whole Numbers	**Yes/No/NA**
1. Estimated number of patients on self-administered medication. (check with pharmacy)	570	
2. If detainee requires continuation of medication, was medication ordered within 24 hours from completion of intake screening? (Review 10 random medical records: Note percent compliance if less than 100%; if 100%, enter "Yes".)		Yes
3. Average lapse time from order to first dose of medication, if greater than 24 hours?	0	
4. Other		

Comments:

Meds provided within 24 hrs however, it is unknown when detainee chooses to take first dose.

Corrective Action Plan(s) (if appropriate):

None

PHARMACY ERRORS		
	Number of Errors	**Number of Incident Reports Submitted**
1. Number of wrong patients.	0	0
2. Number of wrong medications.	0	0
3. Number of wrong doses.	0	0
4. Number of wrong labels.	0	0
5. Number of wrong routes.	0	0
6. Number of MAR errors. (misprinted, medication missing)	0	0
TOTAL:	**0**	**0**

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

MEDICATION REFUSAL

Facility: **Stewart Detention Center**

IHSC QI Audit Tool

Reviewer: LT [redacted]
Quarter/Fiscal Year: 3rd Quarter 2017

PURPOSE: To assess notification of prescribing clinician of poor adherence to medication orders.

Source: Medication administration records, medical record RN, MLP or physician can review.

Sample: Identify 10 patients from MARs who have missed medication on three consecutive days or four or more doses in a week.

Instructions: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Documented refusal in the medical record (with signature of detainee, witness)?
2	Explanation of risks and benefits documented in the medical record?
3	Documentation that prescribing clinician has been notified if 3 consecutive days or 3 consecutive doses and/or 50% of doses missed within 7 days?
4	Documentation of clinician response in the medical record?
5	If detainee refused to sign refusal form, was it documented on the form?

MEDICATION REFUSAL

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5
1	[redacted]	1	1	1	1	1
2		1	1	1	1	1
3		1	1	1	1	1
4		1	1	1	1	1
5		1	1	1	1	1
6		1	1	1	1	1
7		1	1	1	1	1
8		1	1	1	1	1
9		1	1	1	1	1
10		1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):
N/A

PREGNANCY AUDIT (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LCDR (b)(6),(b)(7)(C)
Quarter/Fiscal Year:	3rd Quarter 2017

INSTRUCTIONS: A health care provider will review 100% of the charts of the pregnant patients during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable.

Sample size: 100%

Item #	Measure
1	Was an OB-GYN consult ordered and the scheduled appointment time documented within 7 days of identification of condition? (Not necessarily seen within 7 days) (100%)
2	Prenatal vitamins prescribed? (100%)
3	Proper diet ordered? (100%)
4	Patient education documented at each encounter? (100%)
5	Records reviewed by provider after OB appointment? (100%)
6	Appropriate prenatal labs (consideration for HIV, STI, and viral hepatitis) ordered if not obtained from OB-GYN? (100%)

PREGNANCY AUDIT							
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6
1	N/A						
2							
3							
4							
5							
6							
7							
8							
9							

10							
	PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%

Comments:

N/A; all male facility

Corrective Action Plan(s) (if appropriate):

N/A

MEDICAL HOUSING UNIT (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT [redacted]
Quarter/Fiscal Year:	3rd Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of patients who were admitted to the MHU during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable.

To RANDOMLY select, list out the total number of MHU patients for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

ITEM #	MEASURE
1	Admitting history/current diagnosis or issues documented on the MHU progress note (to be completed by a physician/MLP or appropriate clinician according to scope of practice)? (100%)
2	Appropriate exam documented relevant to the reason for the MHU stay? – e.g. dental, medical, or behavioral health exam? (100%)
3	Provider rounds documented as noted in the treatment plan, if applicable (90%)
4	Treatment plan includes specific instructions for nursing and appropriate precautions or interventions for infectious disease? (90%)

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5 Nursing care plan present? (90%)
6 Nursing care follow-up documented? (100%)
7 Nursing progress notes present for each shift? (100%)
8 24 hour chart review indicated with signature, date and time of review? (90%)
9 Discharge from MHU documented, if applicable (100%)
10 Language Access: Use of translator, provider fluency in language, or English-speaking detainee is documented? (100%)

MEDICAL HOUSING UNIT

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10
1	[redacted]	1	1	1	1	1	1	1	0	1	1
2		1	1	1	1	1	1	0	0	1	1
3		1	1	1	1	1	1	1	1	1	1
4		1	1	1	1	1	1	1	1	1	1
5		1	1	1	1	1	1	1	1	1	1
6		1	1	1	1	0	0	1	0	1	1
7		1	1	1	1	1	1	1	0	1	1
8		1	1	1	1	1	1	1	1	1	1
9		1	1	1	1	1	1	1	1	1	1
10		1	1	1	1	1	1	1	0	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	90%	90%	90%	50%	100%	100%

Comments:

Deficiencies noted with nursing care plan, nursing progress notes for each shift and 24 hr chart reviews were noted.

Corrective Action Plan(s) (if appropriate):

RN mgr to train nursing staff on documentation required for MHU post and ensure they understand the imporatance of thorough, timely documentation.

Add additional 10 records if you fall below the threshold in the table to the right.

Record	Alie
11	[redacted]
12	
13	
14	
15	
16	
17	
18	
19	
20	
	PERCENT CC

Comments:

All areas other than 24 h

Corrective Action Plan(s)

RN mgr to train nursing s

SCREENING AND HEALTH ASSESSMENT (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT [redacted]
Quarter/Fiscal Year:	3rd Quarter 2017

IHSC QI Audit Tool

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review the appropriate number (see page 1) of randomly selected records for patients that have been at the facility for more than two weeks during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

Sample Size: See Instructions in Row 3

Item #	Measure
1	Initial screening completed within 12 hours of admission to facility? (100%)
2	All required areas of the intake template in eCW are completed? (100%)
3	TB screening completed during medical intake if applicable (PPD or CXR)? (100%)
4	PPD read within 48-72 hours? (N/A if CXR performed) (100%)
5	TB clearance properly documented? (100%)
6	Was there timely (NLT 2 working days after identification) follow-up for significant findings of acute and chronic conditions? (100%) (A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health) (100%)
7	Was health assessment completed within 14 days? (100%)
8	Was health assessment completed within 7 days for children? (Family Residential Centers) (100%)
9	Was health assessment completed for patients with chronic illnesses within two working days? (100%)
10	Health assessment (health history and hands-on physical examination) completed by licensed physician/PA/NP/RN (if completed by RN, must have documented training) (100%)
11	If applicable, documentation of transfer summary reviewed within 12 hours? (100%)
12	Patient education documented at each encounter? (100%)
13	Language access: Use of translator, provider fluency in language, or English-speaking patient is documented. (100%)

SCREENING AND HEALTH ASSESSMENT														
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
1	[redacted]	1	1	1	NA	1	1	NA	NA	1	1	1	1	1
2		1	1	1	NA	1	1	NA	NA	1	1	1	1	1
3		1	1	1	NA	1	1	NA	NA	1	1	1	1	1
4		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
5		1	1	1	1	1	NA	NA	NA	NA	NA	1	1	1
6		1	1	1	NA	1	NA	NA	NA	1	1	1	1	1
7		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
8		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
9		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1
10		1	1	1	NA	1	NA	1	NA	NA	1	1	1	1

PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

HYPERTENSION (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT (b)(6),(b)(7)(C)
Quarter/Fiscal Year:	3rd Quarter 2017

IHSC QI Audit Tool

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with hypertension during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with hypertension for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample Size: See Instructions in Row 3

Item #	Measure
1	Blood pressure reading documented at intake? (100%)
2	Patient seen by medical provider within two business days of illness identification (100%)
3	Patient was referred to MLP or higher, if exam was completed by RN (95%)
4	Patient has treatment plan documented? (95%)
5	Diagnosis listed in provider SOAP note? (100%)
6	Diagnosis listed on problem list? (100%)
7	Baseline labs obtained (CBC, CHEM, lipid profile, UA & EKG) and reviewed within 30 days of illness identification? (100%)
8	Patient education documented at each encounter? (100%)
9	Language access: Use of translator, provider fluency in language or English speaking patient is documented? (100%)

HYPERTENSION

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
1	(b)(6);(b)(7)(C)	1	1	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1	1	1
3		1	1	1	1	1	1	1	1	1
4		1	1	1	1	1	1	1	1	1
5		1	1	1	1	1	1	1	1	1
6		1	1	1	1	1	1	1	1	1
7		1	1	1	1	1	1	1	1	1
8		1	1	1	1	1	1	1	1	1
9		1	1	1	1	1	1	1	1	1
10		1	1	1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

HYPE

Record	Alien #
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
	PERCENT COMPLIANCE

Comments:

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Corrective Action Plan(s) (if appropriate):	Corrective Action Plan(s) (if appropri
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

DIABETES (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT [redacted]
Quarter/Fiscal Year:	3rd Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with diabetes during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with diabetes for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample Size: See Instructions in Row 3

Item #	Measure
1	Was PE-C completed within two business days if diabetes was identified at time of arrival? (100%)
2	Documented blood sugar on intake (if diabetes identified at intake) or documented reason for not testing e.g. detainee just ate food one hour ago? (90%)
3	Diagnosis listed in provider SOAP note (100%)
4	Diagnosis listed on problem list? (100%)
5	Baseline A1C obtained within 30 days of arrival or within past 3 months? (100%)
6	Baseline measurement of lipids within 30 days? (100%)
7	Documented prescription of aspirin, as clinically indicated? (80%)
8	Degree of control (goal of HgbA1C < 8.0) documented in treatment plan? (90%)
9	Was a strategy to attain diabetes control documented if HgbA1C was above goal? (100%)
10	Patient education documented at each encounter? (100%)
11	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

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DIABETES												
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11
1	b(6);b(7)(C)	1	0	1	1	1	1	1	0	0	1	0
2		1	1	1	1	1	1	1	NA	NA	1	0
3		1	1	1	1	1	1	0	0	NA	1	1
4		1	1	1	1	1	1	1	NA	NA	1	1
5		1	0	1	1	1	1	1	1	1	1	1
6		1	1	1	1	1	1	1	1	1	1	1
7		1	0	1	1	1	1	1	0	0	1	1
8		1	0	1	1	0	1	1	0	0	1	1
9		1	0	1	1	1	1	NA	NA	NA	1	1
10		1	0	1	1	1	1	NA	0	0	1	1
PERCENT COMPLIANCE		100%	40%	100%	100%	90%	100%	90%	50%	60%	100%	80%

Comments:
Blood sugar on intake not documented/not done; Baseline A1C NOT obtained within 30 days of arrival or within past 3 months; Prescription of aspirin NOT being documented as clinically iindicated; Degree of control (goal of HgbA1C < 8.0) NOT documented in treatment plan; NO strategy to attain diabetes control documented if HgbA1C was above goal.

Corrective Action Plan(s) (if appropriate):

Refresher training will be provided for providers and nurses on all the measures identfied. Training will be incooperated in daily reports.

Add additional 10 records if you fall below the threshold in the table to the right.

DIABETES
Record
11
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Comments:

Corrective A

ASTHMA (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT b(6);b(7)(C)
Quarter/Fiscal Year:	3rd Quarter 2017

IHSC QI Audit Tool

INSTRUCTIONS: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with asthma during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with asthma for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? (100%)
2	Peak flow documented during health assessment (100%)
3	Peak flow documented during all chronic care visits? (100%)
4	Diagnosis listed in provider SOAP note (100%)
5	Diagnosis listed on problem list? (100%)
6	Treatment plan initiated in accordance with chronic care disease guidelines. (90%)
7	Patient education documented at each encounter? (100%)
8	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

ASTHMA

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
1	[redacted]	1	1	1	1	1	1	1	1
2		1	1	NA	1	1	1	1	1
3		1	1	1	1	1	1	1	1
4		1	1	NA	1	1	1	1	1
5		1	1	NA	1	1	1	1	1
6		1	1	NA	1	1	1	1	1
7		1	1	NA	1	1	1	1	1
8		1	1	NA	1	1	1	1	1
9		1	1	NA	1	1	1	1	1
10		1	1	NA	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

ASTHMA - Addit

Record	Alien #	Measure 1
11	N/A	
12		
13		
14		
15		
16		
17		
18		
19		
20		
	PERCENT COMPLIANCE	0%

Comments:

IHSC QI Audit Tool

Corrective Action Plan(s) (if appropriate):	Corrective Action Plan(s) (if appropriate):
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

HIV (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LT (b)(6),(b)(7)(C)
Quarter/Fiscal Year:	3rd Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with HIV during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with HIV for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? (100%)
2	Documented HIV+ by laboratory or prior medical record? (95%)
3	CD4 and viral load obtained within 30 days of disease identification or recent CD4/viral load results obtained from prior record (recent is within the past 90 days)? (95%)
4	Antiretroviral treatment considered and documented? (100%)
5	Treatment plan initiated in accordance with chronic care disease guideline within two business days of illness identification. (95%)
6	Diagnosis listed in provider SOAP note (100%)

7 Diagnosis listed on problem list? (100%)
8 Was patient's care plan evaluated by a physician with experience in managing HIV patients within 30 days of HIV identification or admission to IHSC facility (if diagnosis already known)? (95%) This question was re-worded for FY 2016 for clarity
9 Was the patient seen by a medical provider at least every 90 days? (95%)
10 Was a PPD or IGRA performed within the last year? Note: if the patient has been positive in the past, an annual CXR is acceptable (95%)
11 If applicable, was the CXR completed or verified within 72 hours of health assessment as part of treatment plan? (95%)
12 Patient education documented at each encounter? (95%)
13 Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

HIV														
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
1	[redacted]	1	1	1	1	1	1	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1	1	1	1	1	1	1
3		1	1	1	1	1	1	1	1	0	1	NA	0	1
4		1	1	1	1	1	1	1	1	0	1	NA	1	1
5		1	1	1	1	1	1	1	1	NA	1	1	1	1
6		1	1	0	1	0	1	1	1	1	1	NA	1	1
7		1	1	1	1	1	1	1	0	0	1	1	1	1
8		1	1	1	1	1	1	1	0	NA	1	NA	1	1
9		1	1	1	1	1	1	1	0	1	1	1	1	1
10		1	1	1	NA	1	1	1	0	NA	1	1	1	1
PERCENT COMPLIANCE		100%	100%	90%	100%	90%	100%	100%	60%	60%	100%	70%	90%	100%

Comments:

1 record- (CD4 and viral load NOT obtained within 30 days of disease identification or recent CD4/viral load results obtained from prior record); 1 Record- (Treatment plan NOT initiated in accordance with chronic care disease guideline within two business days of illness identification); 4 Records- (patient's care plan NOT evaluated by a physician with experience in managing HIV patients within 30 days of HIV identification or admission to IHSC);

Corrective Action Plan(s) (if appropriate):

Providers will be re-oriented on Chronic care visits

Add additional 10 records if you fall below the threshold in the table to the right.

TUBERCULOSIS (Detainees being treated for active tuberculosis disease) (ESSENTIAL)

Facility: Stewart Detention Center

IHSC QI Audit Tool

Reviewer: LT [redacted]
Quarter/Fiscal Year: 3rd Quarter 2017

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with tuberculosis (TB) disease during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with TB disease for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	All patients evaluated for TB disease are tested for HIV (100%)
2	Pyrazinamide (PZA) and ethambutol (EMB) prescribed for no more than 60 days unless ordered by the advising physician (100%)
3	TB patients are seen at least monthly by a medical provider for follow-up visits (100%)
4	CXR is obtained 6-8 weeks after initiation of RIPE with comparison to previous CXR(s) (100%)
5	Initial cultures are performed with automatic sensitivity testing and culture and sensitivity results (if at least one culture is positive for M. tb) are reviewed (100%)
6	TB-CM visit note is completed at the time of diagnosis and updated with culture results, drug sensitivity test results (if culture positive), and final case classification within 90 days of diagnosis (100%)

TUBERCULOSIS (ESSENTIAL)

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6
1	[redacted]	1	1	1	NA	1	1
2		1	1	1	1	1	1
3		1	1	1	NA	1	1
4		1	1	1	NA	1	1
5		1	1	1	NA	1	1
6		1	1	1	NA	1	NA
7		1	1	1	NA	1	NA
8		1	1	1	NA	1	NA
9		1	1	1	NA	1	NA
10		1	1	1	NA	1	NA
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%

TUBERCULOSIS (ESSENTIAL) - Additional Records If Firs

Record	Alien #	Measure 1	Measure 2	Measure 3
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
	PERCENT COMPLIANCE	0%	0%	0%

Comments:	Comments:
NA	
Corrective Action Plan(s) (if appropriate):	**Corrective Action Plan(s) (if appropriate):**
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

SEIZURE DISORDER (ESSENTIAL)

Facility:	**Stewart Detention Center**
Reviewer:	**LT** [redacted]
Quarter/Fiscal Year:	**3rd Quarter 2017**

INSTRUCTIONS: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with seizure disorder during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with seizure disorder for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? (100%)
2	2 Documented complete neurological history/assessment at physical examination? (100%)
3	Patient was referred to MLP or higher, if exam was completed by RN (95%)
4	Patient has treatment plan documented? (95%)
5	Diagnosis listed in provider SOAP note? (100%)
6	Diagnosis listed on problem list? (100%)
7	Baseline labs obtained (CBC, CHEM, lipid profile, UA & EKG) and reviewed within 30 days of illness identification? (100%)
8	Patient education documented at each encounter? (100%)
9	Language access: Use of translator, provider fluency in language or English speaking patient is documented? (100%)

SEIZURE DISORDER										
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
1	(b)(6);(b)(7)(C)	1	1	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1	1	1
3		1	1	1	NA	1	1	1	1	1
4		1	1	1	NA	1	1	1	1	1
5		1	1	1	NA	1	1	1	1	1
6		1	1	1	1	1	1	1	1	1
7		1	1	1	1	1	1	1	1	1
8	None	NA	NA	NA	NA	NA	NA	NA	NA	NA
9	None	NA	NA	NA	NA	NA	NA	NA	NA	NA
10	None	NA	NA	NA	NA	NA	NA	NA	NA	NA
PERCENT COMPLIANCE		100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

SEIZUR	
Record	Alien #
11	N/A
12	
13	
14	
15	
16	
17	
18	
19	
20	
PERCENT COMPLIANCE	

Comments:

Corrective Action Plan(s) (if appropri

SICK CALL (URGENT CARE) (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	(b)(6);(b)(7)(C) NP
Quarter/Fiscal Year:	3rd Quarter 2017

IHSC QI Audit Tool

INSTRUCTIONS: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records from patients that have been seen for sick call during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of sick call encounters for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	Vital signs obtained and documented during assessment? (100%)
2	Weight was documented during assessment? (90%)
3	A thorough pain assessment (intensity, duration, quality, better/worse, etc.) was documented during assessment? (100%)
4	Treatment in accordance with nursing guidelines? (100%)
5	If pediatric patient, were pediatric pain guidelines followed? (90%)
6	If appropriate, patient was referred to a higher level of care? (if not appropriate, Enter as N/A) (95%)
7	Patient education documented at each encounter? (100%)
8	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

SICK CALL (URGENT CARE)

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
1	(b)(6),(b)(7)(C)	1	1	1	1	NA	NA	1	1
2		1	1	1	1	NA	NA	1	1
3		1	1	NA	1	NA	NA	1	1
4		1	1	NA	1	NA	NA	1	1
5		1	1	1	1	NA	NA	1	1
6		1	1	1	1	NA	1	1	1
7		1	1	1	1	NA	NA	1	1
8		1	1	1	1	NA	1	1	1
9		1	1	NA	1	NA	NA	1	1
10		1	1	1	1	NA	NA	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

SICK CALL (URGENT CARE

Record	Alien #	Measure 1
11	N/A	
12		
13		
14		
15		
16		
17		
18		
19		
20		
	PERCENT COMPLIANCE	0%

Comments:

Corrective Action Plan(s) (if appropriate):	Corrective Action Plan(s) (if appropriate):
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

MENTAL ILLNESS WITH PSYCHOTROPIC MEDICATIONS (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	LCDR (b)(6);(b)(7)(C)
Quarter/Fiscal Year:	3rd Quarter 2017

INSTRUCTIONS: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with mental illness who take psychotropic medications during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of patients diagnosed with mental illness and prescribed psychotropics during the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was a BH referral made in a timely manner (within 72 hours of intake or identification)? (100%)
2	Diagnosis listed by behavioral health provider in encounter note (100%)
3	Diagnosis listed on problem list? (100%)
4	If patient takes psychotropic medication, psychotropic medication consent (special consent form) signed for the drug ordered? (100%)
5	Clinical assessment, treatment, and follow up plan documented? (100%)
6	For patients on antipsychotic medication, was there an AIMS (Abnormal Involuntary Movement Scale) test performed? (100%) (physician, MLP, RN can conduct an AIMS test)
7	Was appropriate lab monitoring ordered depending on the psychotropic drug? (100%)

MENTAL ILLNESS WITH PSYCHOTROPIC MEDICATIONS	MENTAL ILLNESS WITH PSYCHOTROPIC MED Below T

IHSC QI Audit Tool

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	[redacted]	1	1	1	0	1	NA	NA
2		1	1	1	NA	1	NA	NA
3		1	1	1	1	1	NA	NA
4		1	1	1	1	1	NA	NA
5		1	1	1	0	1	NA	NA
6		1	1	1	0	1	NA	NA
7		1	1	1	1	1	NA	NA
8		1	1	1	NA	1	NA	NA
9		1	1	1	NA	1	NA	NA
10		1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	70%	100%	100%	

Comments:
Three instances of psychotropic medication consents missing from EMR

Corrective Action Plan(s) (if appropriate):
BHPs reminded to have detainee sign psychotropic medication consents when pts are seen during tele-psychiatry and to ensure that a consent is on file for detainee with meds ordered/re-ordered by onsite physicians or MLPs. All staff will be reminded of importance of having psychotropic med consents completed at time of service to ensure compliance with standard.

N/A

Add additional 10 records if you fall below the threshold in the table to the right.

Record	Alien #	Measure 1	Measure 2
11	[redacted]	1	1
12		1	1
13		1	1
14		1	1
15		1	1
16		1	1
17		1	1
18		1	1
19		1	1
20		1	1
	PERCENT COMPLIANCE	100%	100%

Comments: Second data set revealed no concerns.

Corrective Action Plan(s) (if appropriate):

All staff will be more diligent in adhering to this standard.

DENTAL CARE (ESSENTIAL)

Facility:	Stewart Detention Center
Reviewer:	CAPT [redacted]
Quarter/Fiscal Year:	3rd Quarter 2017

IHSC QI Audit Tool

INSTRUCTIONS: A dentist, dental hygienist, RN, mid-level provider or physician will review appropriate number (see page 1) of records from patients seen by a dentist for treatment within the designated time frame.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

If there are not enough medical records to select the required number of records to review, 100% review will be required.

Sample size: See Instructions in Row 3

Item #	Measure
1	Was dental (oral) screening completed and documented within 14 days of arrival to facility (adults)? ***oral screening includes visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist? (100%)
2	Was dental (oral) screening completed and documented within 7 days of arrival to facility (children)? (100%)
3	If applicable, was patient evaluated within 48 hours of referral? (100%)
4	Does clinical note describe findings, diagnosis/assessment, treatment plans? (100%)
5	If applicable, patient scheduled for follow-up treatment as recommended? (100%)
6	Was the oral examination completed by a dentist or scheduled within 12 months of arrival to facility for adults? (100%) - oral examination by a dentist includes taking or reviewing the patient's oral history, an oral health and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral cavity.
7	Was the oral examination completed by a dentist or scheduled within 60 business days of arrival to facility for children? (100%)

DENTAL CARE

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	[redacted]	1	NA	1	1	1	1	NA
2		1	NA	1	1	NA	1	NA
3		1	NA	1	1	NA	1	NA
4		1	NA	1	1	1	1	NA
5		1	NA	1	1	NA	1	NA
6		1	NA	1	1	1	1	NA
7		1	NA	1	1	1	1	NA
8		1	NA	1	1	1	1	NA
9		1	NA	1	1	NA	1	NA
10		1	NA	1	1	1	1	NA
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

DENTAL CARE - Additional Reco

Record	Alien #	Measure 1	Measure 2
11	N/A		
12			
13			
14			
15			
16			
17			
18			
19			
20			
	PERCENT COMPLIANCE	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):	Corrective Action Plan(s) (if appropriate):
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

CONTINUITY OF CARE REVIEW (ESSENTIAL)

Facility: Stewart Detention Center
Reviewer: (b)(6);(b)(7)(C) FNP
Quarter/Fiscal Year: 3rd Quarter 2017

INSTRUCTIONS: Health staff (any IHSC staff) will review appropriate number (see page 1) of randomly selected records of patients who went to the Emergency Department during the current quarter.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

To RANDOMLY select, list out the total number of applicable medical records for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See Instructions in Row 2

Item #	Measure
1	Was a discharge summary/instructions requested or present? (100%) – (was a discharge summary/instructions received when the patient returned from the hospital?)
2	Was there a note from the IHSC provider detailing the reason the detainee was sent to the ED? (100%)
3	Was a note entered in the medical record upon the detainee's return to the facility listing the ED/hospital's recommended plan of care? (100%)
4	Did the provider follow the ED/hospital's recommended plan of care? (100%)
5	Upon return from ED, was the patient/parent educated about diagnosis, medications (if applicable) and treatment plan? (100%)
6	Is there documentation acknowledging patient/parent understands treatment plan? (100%)
7	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? (100%)

CONTINUITY OF CARE								
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	(b)(6);(b)(7)(C)	1	1	1	1	1	1	NA
2		1	1	1	1	1	1	1

CONTINUITY OF CARE - Additional R			
Record	Alien #	Measure 1	Measure 2
11			
12			

3	[redacted]	1	1	1	1	1	1	NA
4		1	1	1	1	1	1	NA
5		1	1	1	1	1	1	1
6		1	1	1	1	1	1	NA
7		1	1	1	1	1	1	1
8		1	1	1	1	1	1	1
9		1	1	1	1	1	1	1
10		1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

13			
14			
15			
16			
17			
18			
19			
20			
	PERCENT COMPLIANCE	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):

Add additional 10 records if you fall below the threshold in the table to the right.

REASONABLE ACCOMMODATIONS SELF-ASSESSMENT

Facility:	**Stewart Detention Center**
Reviewer:	**LCDR** [redacted]
Quarter/Fiscal Year:	**3rd Quarter 2017**

INSTRUCTIONS: Obtain the information from the HSA's Reasonable Accommodation Self-Assessment Tool.

Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

REASONABLE ACCOMMODATIONS SELF-ASSESSMENT	
POLICY, PROCEDURES, and TRAINING	**YES (1) or NO (0)**
1. Procedures are in place to ensure detainees with disabilities are informed of and have an equal opportunity to request and obtain health services.	1

2. IHSC staff has received initial training on interacting with individuals with disabilities and individuals requiring reasonable accommodations, and annually thereafter.	1
3. Written evacuation procedures and emergency communications are in place in the clinic for individuals with disabilities.	1
4. Procedures have been established to ensure that accessible features (within the IHSC-staffed facilities) are maintained. (Enter N/A if non-applicable)	1
PHYSICAL ACCESSIBILITY	
5. The facility provides reasonable accommodation access for individuals within the Health Unit.	1
COMMUNICATION	
6. The IHSC clinic has access to sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities.	1
PERCENT COMPLIANCE:	**100%**
Comments: **N/A**	
Corrective Action Plan(s) (if appropriate): **N/A**	

TREATMENT OF DISABILITIES

Facility:	**Stewart Detention Center**
Reviewer:	**LT** [redacted]
Quarter/Fiscal Year:	**3rd Quarter 2017**

IHSC QI Audit Tool

PURPOSE: To assess care of detainees who need accommodation for their disabilities. An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment.
(see http://www.ada.gov/q%26aeng02.htm , accessed January 20, 2012).

An RN, MLP or physician can review.

SOURCE: Facility logs or tour of facility and interviews with detainees who need accommodation.

Sample: 10 detainees within the population who have a disability that requires special medical treatment. Determine through medical record examination if appropriate treatment and accommodation was given.

Instructions: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations? (100%)
2	Was the detainee assessed to determine if the disability limits one or more major life activity (as defined by ADA: basic activities that the average person in the general population can perform with little or no difficulty, such as (but not limited to) caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, concentrating, thinking, interacting with others and working. A major life activity can also include the operation of a major bodily function)?
3	Were appropriate special orders entered (e.g., lower bunk, assistive device, meal, etc.)? (100%)
4	Was ADL assistance provided? (100%)

TREATMENT OF DISABILITIES

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4
1	[redacted]	1	1	1	NA
2		1	1	1	NA
3		1	1	1	NA
4		1	1	1	NA
5		1	1	1	NA
6		1	1	1	NA
7	NA	NA	NA	NA	NA
8	NA	NA	NA	NA	NA
9	NA	NA	NA	NA	NA
10	NA	NA	NA	NA	NA
	PERCENT COMPLIANCE	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):
N/A

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

Facility:	Stewart Detention Center
Reviewer:	(b)(6),(b)(7)(C) NP
Quarter/Fiscal Year:	3rd Quarter 2017

PURPOSE: To assess timeliness of off-site diagnostic services and specialty care.

SOURCE: Statistics

MLP or physician can review.

SAMPLE: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

INSTRUCTIONS: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Documented time urgency on order? (90%)
2	Accomplished within 45 days of order or within ordered timeframe, e.g., "return in 90 days"? (100%)
3	Documented re-evaluation of patient for deterioration each 30 days in excess of time urgency on order? (90%)
4	Clinician acknowledgement and report in medical record within 7 days? (90%)
5	Detainee informed of results or reason for delay if not scheduled? (90%)

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS							
Record	Alien #	Clinic	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5
1	(b)(6),(b)(7)(C)	Optometry	NA	NA	NA	NA	1

DIAGNOSTIC SERVICES AND SPECIALTY CAR Below T		
Record	Alien #	Clinic
11		

2		[redacted]	Orthopedics	1	1	1	1	1
3			Radiology	1	1	1	1	1
4			Cardiology	1	1	1	1	1
5			Endocrinology	1	1	1	1	1
6			Cardiology	1	1	1	1	1
7			Gastroentology	1	1	1	1	1
8			Neurology	1	1	1	1	1
9			Neurology	1	1	1	1	1
10			Podiatry	1	1	1	1	1
			PERCENT COMPLIANCE	100%	100%	100%	100%	100%

12		
13		
14		
15		
16		
17		
18		
19		
20		
		PERCENT COMPLIANCE

Comments:

N/A

Comments:

Corrective Action Plan(s) (if appropriate):

N/A

Corrective Action Plan(s) (if appropriate):

Add additional 10 records if you fall below the threshold in the table to the right.

LABORATORY AND DIAGNOSTICS

Facility:	Stewart Detention Center
Reviewer:	LT [redacted]
Quarter/Fiscal Year:	3rd Quarter 2017

IHSC QI Audit Tool

PURPOSE: To assess timeliness, continuity, and coordination of care.

Source: Laboratory log.

RN, MLP or physician can review.

Sample: 10 most recent orders for acute labs, not including routine testing for detainees with chronic illness.

Instructions: Enter "1" for Yes, "0" for No, and "NA" for Not Applicable. Do not leave any blank.

Item #	Measure
1	Up to date certification for CLIA-waived testing accessible? (100%)
2	Documentation of applicable staff training for performing CLIA-waived tests? (100%)
3	Blood drawn or test done within 1 business day of ordered date? (100%)
4	Results received within 24 hours or as appropriate? (100%)
5	Clinician acknowledgment? (100%)
6	Appropriate clinical response? (100%)
7	Detainee informed of results; if not, reason documented in medical record? (100%)

LABORATORY AND DIAGNOSTICS

Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	(b)(6);(b)(7)(C)	1	1	1	1	1	1	1
2		1	1	1	1	1	1	1
3		1	1	1	1	1	1	1
4		1	1	1	1	1	1	1
5		1	1	1	1	1	1	1
6		1	1	1	1	1	1	1
7		1	1	1	1	1	1	1
8		1	1	1	1	1	1	1
9		1	1	1	1	1	1	1
10		1	1	1	1	1	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%

Comments:

N/A

LABORATORY AND DIAGNOSTICS - Additional

Record	Alien #	Measure 1	Measure 2
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
	PERCENT COMPLIANCE	0%	0%

Comments:

Corrective Action Plan(s) (if appropriate):	Corrective Action Plan(s) (if appropriate):
N/A	

Add additional 10 records if you fall below the threshold in the table to the right.

CREDENTIALING

Facility:	Stewart Detention Center
Reviewer:	CAPT [redacted]
Quarter/Fiscal Year:	3rd Quarter 2017

Purpose: To assess credentials of all health care professionals, ensuring they are legally qualified to provide services consistent with licensure, certification, and registration requirements of the practicing jurisdiction.

Source: Up to 10 fields for each of all licensed health care professionals.

HSA or AHSA will review

Instructions: Enter as "1" for yes, "0" for no, and "NA1" for not applicable. Do not leave any area blank.

Sample: 10 chosen at random

Item # Measure

1 Documentation of primary source validation (e.g., internet) of current license, certification or registrations for all applicable licensed professionals (100%)
2 Validation of DEA for physicians, psychiatrists, and dentists? (100%)
3 Current CPR certificate (100%)
4 Documentation of inquiry regarding sanctions or disciplinary actions of state boards, employers, and the National Practitioner Data Bank (NPDB) (100%)

CREDENTIALING					
Record	Employee	Measure 1	Measure 2	Measure 3	Measure 4
1	NP	1	NA	1	1
2	NP	1	NA	1	1
3	NP	1	NA	1	1

4	PA	1	NA	1	1
5	DO	1	1	1	1
6	RN	1	NA	1	1
7	DP	1	NA	1	1
8	NP	1	NA	1	1
9	RN	1	NA	1	1
10	LPN	1	NA	1	1
	PERCENT COMPLIANCE	100%	100%	100%	100%

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

MORTALITY REVIEW

Facility:	**Stewart Detention Center**
Reviewer:	**LCDR** [redacted]
Quarter/Fiscal Year:	**3rd Quarter 2017**

IHSC QI Audit Tool

INSTRUCTIONS: To determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

SOURCE: Minutes, notes, medical records, emergency response, and other pertinent documents.

MLP or physician will review.

INSTRUCTIONS: Enter as "1" for yes, "0" for no, and "NA" for not applicable. Do not leave any area blank.

SAMPLE: All in-custody deaths, including those in hospital, within the past quarter. If applicable, most of the information can be requested through the HAS or designee.

ITEM #	MEASURE
1	Multidisciplinary mortality review (clinical, administrative) within 30 calendar days of death (this review is completed by HQ. Request information from HSA)? (100%)
2	Follow-up review when autopsy and toxicology reports are available? (100%)
3	Assessment as to whether the medical response was appropriate on the day of death or transfer to the hospital? (100%)
4	Assessment as to whether earlier intervention was possible and whether that would have changed the outcome? (100%)
5	Analysis of ways to improve patient care, independent of the cause of death or RCA completed? (100%)
6	For suicides only, was there a psychological autopsy ordered/completed? (100%)
7	Was the involved staff informed of the clinical mortality review and administrative findings? (100%)
8	Was treating staff informed of the clinical mortality review and administrative findings? (100%)

DEFINITION:

Clinical mortality review is an assessment of clinical care provided and the circumstances leading up to the death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved. (This information is collected by the HSA, IHSC Compliance Investigations and Risk Management)

Administrative morality review is an assessment of correctional and emergency response actions surrounding the detainee's death. Its purpose is to identify areas where facility operations, policies and procedures can be improved. (This information is collected by the HSA, IHSC Compliance Investigations and Risk Management)

MORTALITY REVIEW									
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
1	(b)(6),(b)(7)(C)	1	1	1	1	1	1	1	1
2									
3									
4									
5									
6									
7									

8									
9									
10									
	PERCENT COMPLIANCE	100%	100%	100%	100%	100%	100%	100%	100%

Comments: One completed suicide during this review period. Mortality review committee and OPR ensured facility's compliance with administrative checks and that timely dissemination of findings and best practice recommendations were provided.

Corrective Action Plan(s) (if appropriate):
Facility will ensure that all staff has completed mandatory training related to identification of potentially suicidal detainees and suicide prevention.

MEDICAL RECORDKEEPING PRACTICES

Facility:	Stewart Detention Center
Reviewer:	(b)(6),(b)(7)(C)
Quarter/Fiscal Year:	3rd Quarter 2017

INSTRUCTIONS:
- This worksheet should be filled out following the performance-based reviews.
- Put a "1" in the appropriate column (Yes, Partial, No, or N/A) for each measure.
  - o For example, if all 10 records comply with "identifying information", then a 1 should be placed in the YES column.
  - o If only some of the records comply, a 1 should be placed in the PARTIAL column.
  - o If none comply, a 1 should be placed in the NO column.
  - o Only put a 1 in ONE of the 4 columns (Yes/Partial/No/NA) for each criteria.
- For all answers that are "partial compliance" or "non-compliance," the reviewer should write a comment.
  - o For example, if most of the progress notes are legible, but one or two practitioners' notes are barely legible, the appropriate comment would be "Dr. XX.s notes are not legible."
- Reviewer can be any health care provider.

SAMPLE: 10 Records reviewed on detainees with chronic disease.

MEDICAL RECORDKEEPING PRACTICES

IHSC QI Audit Tool

		YES	PARTIAL	NO	N/A	COMMENTS
1	Identifying information (100%)	1				
2	Current problem list (100%)	1				
3	Receiving screen and health assessment forms (100%)	1				
4	Progress notes (100%)	1				
5	Clinician orders for medication, signed (100%)	1				
6	MARs (100%)	1				
7	Lab and diagnostic reports (100%)	1				
8	Flow sheets (100%)	1				
9	Consent, refusal, and release of information forms (100%)	1				
10	Results of specialty consultations and referrals (100%)	1				
11	Discharge summaries from ED and hospitalizations (100%)	1				
12	Special needs treatment plan, where applicable (100%)	1				
13	Immunizations records, where applicable (100%)	1				
14	Date and time of each encounter (100%)	1				
15	Integrated medical, dental, and mental health record (100%)	1				
16	Timely filing, within 72 hours (100%)	1				
17	Consolidated medical record (100%)	1				
18	Content organized for easy retrieval (100%)	1				
19	EHR password protected, by individual (100%)	1				
20	Integrated health information with EHR, where applicable (100%)	1				
	PERCENT COMPLIANCE	100%	0%	0%	0%	

Comments:

N/A

Corrective Action Plan(s) (if appropriate):

N/A

Evaluate an additional 10 records if you fall below the threshold in parentheses. Follow the instructions above the table to include the results for the additional 10 records in the appropriate columns of the table.

42
e of Total opulation
2%

MEDICAL HOUSING UNIT - Additional Records If First 10 Are Below Threshold										
:n #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10
[redacted]	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	0	1	1
	1	1	1	1	1	1	1	0	1	1
)MPLIANCE	100%	100%	100%	100%	90%	100%	90%	40%	100%	100%

r chart reviews came into compliance.

(if appropriate):

:taff on documentation required for MHU post and ensure they understand the imporatance of thorough, timely documentation.

SCREENING AND HEALTH ASSESSMENT - Additional Records If First 10 Are Below Threshold														
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
11														
12														
13														
14														
15														
16														
17														
18														
19														
20														

PERCENT COMPLIANCE	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Comments:													
Corrective Action Plan(s) (if appropriate):													

RTENSION - Additional Records If First 10 Are Below Threshold								
Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
0%	0%	0%	0%	0%	0%	0%	0%	0%

iate):

- Additional Records If First 10 Are Below Threshold

Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11
(b)(6);(b)(7)(C)	1	0	1	1	1	1	0	0	0	1	1
	1	1	1	1	1	1	1	1	1	1	1
	1	1	1	1	1	1	NA	0	NA	1	1
	0	1	1	1	1	1	NA	1	NA	1	1
	NA	NA	1	1	NA	NA	NA	1	NA	1	1
	1	0	1	1	1	1	NA	1	NA	1	1
	1	1	1	1	1	1	NA	NA	NA	1	1
	1	1	1	1	1	1	NA	1	1	1	1
	NA	NA	1	1	1	1	0	0	NA	1	1
	1	NA	1	1	1	1	0	1	1	1	1
PERCENT COMPLIANCE	100%	80%	100%	100%	100%	100%	70%	70%	90%	100%	100%

ction Plan(s) (if appropriate):

ional Records If First 10 Are Below Threshold						
Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
0%	0%	0%	0%	0%	0%	0%

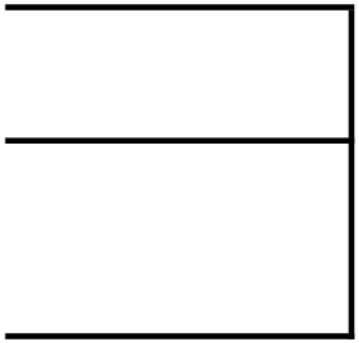
HIV - Additional Records If First 10 Are Below Threshold														
Record	Alien #	Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9	Measure 10	Measure 11	Measure 12	Measure 13
11	[redacted]	1	1	NA	1	1	1	1	1	1	1	1	1	1
12		1	1	1	1	1	1	1	1	1	1	1	1	1
13		1	1	1	1	1	1	1	1	1	1	1	1	1
14		1	1	1	1	1	1	1	1	NA	1	1	1	1
15		1	1	1	1	1	1	1	NA	1	1	1	1	1
16	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
17	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
18	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
19	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
20	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
PERCENT COMPLIANCE		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Comments:

Unable to find additional 10 records

Corrective Action Plan(s) (if appropriate):

t 10 Are Below Threshold		
Measure 4	Measure 5	Measure 6
0%	0%	0%



E DISORDER - Additional Records If First 10 Are Below Threshold								
Measure 1	Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8	Measure 9
0%	0%	0%	0%	0%	0%	0%	0%	0%

iate):

E) - Additional Records If First 10 Are Below Threshold						
Measure 2	Measure 3	Measure 4	Measure 5	Measure 6	Measure 7	Measure 8
0%	0%	0%	0%	0%	0%	0%

DICATIONS - Additional Records If First 10 Are
Threshold

Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
1	1	1	1	1
1	1	1	1	1
1	1	1	NA	NA
1	1	1	NA	NA
1	1	1	NA	NA
1	1	1	1	1
1	1	1	NA	NA
1	1	1	NA	NA
1	1	1	NA	NA
1	1	1	NA	NA
100%	100%	100%	100%	100%

rds If First 10 Are Below Threshold				
Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
0%	0%	0%	0%	0%

ecords If First 10 Are Below Threshold				
Measure 3	Measure 4	Measure 5	Measure 6	Measure 7

0%	0%	0%	0%	0%

E ACCESS - Additional Records If First 10 Are hreshold				
Measure 1	Measure 2	Measure 3	Measure 4	Measure 5

0%	0%	0%	0%	0%

Records If First 10 Are Below Threshold				
Measure 3	Measure 4	Measure 5	Measure 6	Measure 7
0%	0%	0%	0%	0%

Workbook Protection

(b)(7)(E)

Password for protected sheets: ' (b)(7)(E)

CONTINUOUS QUALITY IMPROVEMENT AUDIT TOOL
4th Quarter- FY 2017

- **Grievances**

Comments: A total of 8 grievances were received within the quarter; 1 -detainee left the next day and his grievance could not be processed, and 1 case was **NOT** addressed within 5 days

Corrective Action Plan(s) (if appropriate): An alternate staff member needs to be identified; He/she will address grievances when the primary staff member is unavailable, thus ensuring grievances are addressed in a timely manner.

- **Suicide watch**

Comments: 15 minute forms completed by Correctional Officers are missing.

Corrective Action Plan(s) (if appropriate): BHPs will ensure that the missing observation logs are located, completed in their entirety and forwarded to MRTs for scanning into the detainees' EMR. All staff will be reminded, educated and trained on importance of ensuring that observation logs are thoroughly completed and accounted for daily. Core Civic leadership will be informed during quarterly suicide prevention meeting to educate staff on maintaining all forms

- **Hunger Strike**

Comments: Nursing staff is not using the MHU: Hunger strike Monitoring Form/MHU: Intakes & Outputs form to record intakes/outputs or significant findings from labs. 1-record revealed detainee refusing nursing assessments. Every detainee on hunger strike had regular provider contact throughout their time on hunger strike

Corrective Action Plan(s) (if appropriate): In service training will be provided to the nursing staff on proper document ion related to hunger strike. Medical staff will continue to conduct their evaluations and make eCW entries for all MHU pts in a timely manner.

- **Medication Administration Errors**

Comments: -6 medications were missed (Detainees failed to show up to pill line).

Corrective Action Plan(s) (if appropriate): Medical staff will continue to communicate with the correctional officers to ensure that detainees are escorted to the pill line for their meds; Detainees not willing to come for their meds will sign refusal forms.

- **PRESCRIBING/ORDERING ERRORS**

Comments: 2 orders were written incorrectly; 1 drug had the wrong indication; and 1 wrong dose

CONTINUOUS QUALITY IMPROVEMENT AUDIT TOOL
4th Quarter- FY 2017

Corrective Action Plan(s) (if appropriate): -Improved communication between providers, nurses, and pharmacy ; Educate providers on double checking orders; Nurses should read back orders to the providers after taking verbal orders

- **PHARMACY ERRORS**

Comments: #2- Extended release medication given instead of immediate release; Future start date for a medication not printed in MAR

Corrective Action Plan(s) (if appropriate): MARs to be reviewed by the Clinic Coordinator/Nurse Manager daily.

- **MEDICAL HOUSING UNIT**

Comments: -No nursing care plan with one pt. record

Corrective Action Plan(s) (if appropriate): In service training to be provided to the nurses on Nursing Care Plan

- **DIABETES**

Comments: Blood sugar on intake not documented/not done; Baseline A1C NOT obtained within 30 days of arrival or within past 3 months; Prescription of aspirin NOT being documented as clinically iindicated; Degree of control (goal of HgbA1C < 8.0) NOT documented in treatment plan; NO strategy to attain diabetes control documented if HgbA1C was above goal;

Corrective Action Plan(s) (if appropriate): Refresher training will be provided for providers and nurses on all the measures identified. Training will be in cooperated in daily reports.

- **ASTHMA**

Comments: - Peak flows are not being documented during health assessment and chronic care visits; Providers are not utilizing SFs (smart forms/Chronic care templates) and when utilized they are not completely filled out, thus leaving out vital information; 1- record showed no assessment completed within 2 days.

Corrective Action Plan(s) (if appropriate): - Finding will be discussed during the providers' meeting, and measures would be made available to all provider for reference. Providers encounters will be reviewed weekly, and further training will be made available to providers if the need arises.

- **HIV**

Comments: 1 record- (PE-C was not completed within 2 days); 1 Record- (Diagnosis not listed in provider note); 1- PPD or IGRA not performed within the last year

Corrective Action Plan(s) (if appropriate): HIV management protocol to be in cooperated into providers' meeting